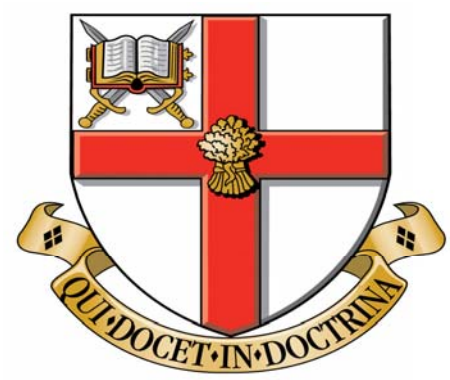

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The Impact of a Traumatic Birth:

An Exploration of Mothers' Experiences

Ann Todd

Dissertation submitted to the University of Chester for the Degree of Master of Arts (Clinical Counselling) in part fulfilment of the Modular Programme in Clinical Counselling.

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Abstract

This study took a qualitative approach to explore mothers' experiences of the impact of traumatic birth. Four women who had experienced a self-defined traumatic birth took part in taped semi-structured interviews. Interpretative phenomenological analysis was chosen as the means of evaluation. The research found mothers experienced feelings of fear, shock and being out of control during the trauma. Coping mechanisms of dissociation and repression were reported. Feelings of failure, anger, inadequacy and depression featured postpartum. The trauma also impacted on marital relationships, mother baby bonding, attachment behaviour and decisions about future pregnancies. Post traumatic growth was also a feature of the impact of traumatic birth.

Declaration

This work is original and has not been submitted previously in support of any qualification or course.

Signed:

Name: Ann Todd

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Chapter One

Introduction

Background

Childbirth is a rite of passage, described by many women as a natural, exhilarating and life enhancing process. Tragically research suggests that as many as one in three women would describe their birth experience as traumatic and as a consequence have experienced post-traumatic stress symptoms (Creedy, Shochet and Horsfall, 2000; Soet, Brack, Dilorio, 2003; Ayers, Harris, Sawyer, Farfitt and Ford, 2009). Despite these substantial figures, recognition and support for a woman's distress is often unforthcoming. After all, this event has resulted in the birth of a healthy baby, something to be celebrated. As a result recognition of the woman's trauma is often overlooked by medical staff as they commend a good outcome and perhaps by family and friends as they revel in the excitement of a new baby.

There has been an increased interest in birth trauma in the last 15 years. However, Elmir, Schmied, Wilkes and Jackson (2010) point out that there is neither a consistent definition of traumatic birth nor any systematic way to access birth trauma. Beck (2004a), would define it as "actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control and horror" (p.28). Reid (2011) defines traumatic delivery simply as the woman feeling traumatised by her experience and is fearful of a subsequent birth. Meanwhile in the trauma field there has been growing acceptance that what constitutes trauma is subjective (Miliora, 1998). Beck's (2004a) study on birth trauma

attests to this. Her study found that participants perceived their traumatic experience was often viewed as routine by the medical staff. As a result she concluded that birth trauma “lies in the eyes of the beholder” (Beck, 2004a, p28).

Research has reported that in relation to birth trauma women feel violated, helpless and experience intense fear of death or injury to either themselves or their baby (Ryding, Wijma and Wijma, 1998). The negative repercussions can be both on-going physical and psychological difficulties. Women may experience a myriad of emotions including anger, anxiety, depression and disappointment, and may have an altered sense of self which may leave them feeling inadequate and not whole (Allen, 1998; Ayers, Eagle and Waring, 2006; Beck, 2004a). Research has also informed us that the impact of traumatic birth can affect a woman’s attachment to her baby (Ballard, Stanley and Brockington, 1995; Allen 1998; Soet, Brack, and Dilorio, 2003); affect her relationship with her partner (Fones, 1996); and decisions about future children (Bailham & Joseph, 2003; Beck, 2010). One can see a complex range of emotions and outcomes which affect the woman and which can ripple into society at large.

Indicated rates of post traumatic stress disorder (PTSD) in women following a traumatic birth, range from 1.7% (Wijma, Wijma and Soderquist, 1997) to 5.6% (Creedy, Shochet and Horsfall, 2000; Adewuya, Ologun and Ibigbami, 2006). However many more women experience a range of post traumatic stress symptoms which fall short of a full PTSD diagnosis, the prevalence of which has been measured at up to 33% (Creedy et al, 2000). In mentioning diagnostics I do not want to pathologise what most now see as a normal reaction to an abnormal event (Carll, 2007; Ayers, 2004). Nor would I want to confine a woman’s experience to a list of symptoms. Post traumatic stress exists along a continuum and women’s reactions to

traumatic birth will be individual rather than standard (White, Matthey, Boyd and Barnett, 2006).

Whilst most hospitals offer some form of postnatal service, the offering differs from hospital to hospital. But as post traumatic stress symptoms do not necessarily appear immediately after the trauma, in fact symptoms may not appear until months later, the mother might well have moved out of the postnatal care system (Peeler et al, 2013). One can imagine how a woman, coming to terms with the demands of a new baby, may be hesitant to seek help. After all feelings of failure, inadequacy and post traumatic stress symptoms are at odds with society's expectations of contented motherhood. A mother may be left to process her experience alone.

Aims and Rationale

My interest in this area is a consequence of my own experience of a traumatic birth. After the birth of my daughter I suffered from HELLP syndrome, a life threatening complication of pregnancy. Whilst the medical care given to save my life was admirable, my emotional health was given no attention. It maybe that little has changed in the intervening years. A recent report by Peeler et al. (2013), suggests that postnatal support is still focused on physical rather than psychological needs.

My own experience of birth trauma produced the dichotomous feelings of love and delight in having a daughter; feeling so lucky to be alive; whilst simultaneously feeling inadequate in my failure to have a "normal" birth; feelings of guilt for the agonising worry I had put my husband and family through; and an almost unbearable thought that I could have left my child motherless. My experience has given me some

awareness of the complexity of emotions and the difficulty of expressing these at a time that should arguably be the happiest of your life.

My aim was to gain a rich in-depth understanding of the complex meaning of the impact of traumatic childbirth. I sought answers to the following two questions:

- How did my participants process and make sense of their experience?
- How did their lived experience impact on their lives in the months and years following their birth trauma?

The Birth Trauma Association (n.d.) state that, in the UK alone, it is estimated that 10,000 women a year may experience PTSD as a result of a traumatic birth and a further 200,000 may feel traumatised and develop some symptoms. However the study into the impact of traumatic birth is a relatively new area for research, consequently the amount of qualitative research available is moderate. I therefore hope my study will add value to the current research discussion. I also anticipate that the insight gained from this research will be enlightening and helpful for my own counselling practice and the wider counselling community. Given the magnitude of the problem, there is a high probability that counsellors will encounter clients who have suffered a traumatic birth. This is therefore a useful piece of research for any counsellor to read. I hope counsellors who do so, will gain valuable insight which will broaden their understanding, sensitivity and empathy.

Chapter Two

Literature Review

Research Strategy

The search for relevant literature was carried out during the period December 2012 to August 2013. The primary method used to retrieve relevant data was an electronic literature search of databases, namely PsycARTICLES, Psyc-INFO, PsycBOOKS, Psychology & behavioural science collection, SocINDEX and CINAHL. Search terminology focused on birth trauma and impact. Full details of the search terminology and methodology used can be found in Appendix One. Chester University library and the Google search engine were also utilised. Further sources were located by using the references of papers retrieved from the other research strategies. I also made contact with a leading researcher in this field, who was generous in provision of her findings and leads to relevant literature and blog sites. Finally as a result of the content of my research interview more research was carried out in targeted areas, for example Post-traumatic Growth.

Given that this is a relatively new area of research the literature retrieved is all dated within the last twenty years, that is, since 1993.

Results of the Literature Review

The search resulted in papers predominantly focusing on Post-traumatic Stress Disorder (PTSD) and sub-syndromal Post-traumatic Stress Symptoms (PTSS). The majority of the papers focused on incidence and causal factors. As this research

focuses on the impact, it was decided that information on causal factors would be outside the focus of this review.

None of my participants were diagnosed with nor tested for PTSD, although some described symptoms which matched PTSS. It may therefore have seemed fitting to concentrate on literature which focused on PTSS. However there is much controversy regarding the subjective nature of the diagnosis of PTSD (White et al, 2006) and the results of this literature review revealed divergence between researchers with regards to the measures used for classification of PTSD. There is therefore some doubt over whether women in some of the studies meet the diagnostic criteria for PTSD (Olde et al, 2006; Alcorn et al 2010). Given the nature of this research and the fact that post traumatic stress is experienced on a continuum anyway, it therefore seemed appropriate to review papers regardless of their focus on PTSD or PTSS.

The following review should be taken in the context that many women who are subject to a traumatic birth will not experience PTSD or PTSS. The trauma may never the less have an impact on their lives.

Historical Context

PTSD was given formal recognition in DSM-III in 1980 and was defined as an anxiety disorder resulting from exposure to extreme events which were outside of the normal human experience (APA, 1980). Given that the initial research work on PTSD came from the study of Vietnam War Veterans, it is understandable that the nature of these extreme events was on the scale of war, natural and manmade disasters, rape and

torture. Childbirth would not be recognised in this classification because it is a normal event for approximately half of the population (Olde et al, 2005). In 1994 there was a change in criteria. DSM-IV (APA, 1994) criteria stated a person has to have experienced or witnessed an incident which involved actual or threatened death or serious injury and that person's response is intense fear, helplessness or horror. This of course could describe what some women experience in child birth.

Full diagnostic criteria for PTSD are contained in Appendix 2. The latest addition, DSM V (APA, 2013), is outside of this review as it was published after research interviews took place.

Interest in birth as a traumatic event began to take hold and case studies reports of women experiencing PTSD symptoms following childbirth emerged in the mid-1990s (Ballard et al, 1995: Fones 1996). A quantitative study by Wijma et al. (1997) and a qualitative study by Allen (1998) were the first of a series of studies examining prevalence and predictors, which seemed to be the focus of research for the next ten years. More recently research has started to look at the longer term implications of birth trauma such as relationships with partners; mother-child relationships and the impact on future childbearing.

At about the same time as the interest in birth trauma arose, another area of trauma began to raise its profile. Traditionally the emphasis in trauma research has focused on adverse medical, psychological and societal effects. In the 1990s interest also turned to the positive changes that could occur following trauma. Whilst this has been given a number of labels the term Posttraumatic Growth (PTG) became the most prevalent. Initially PTG was recognised as a result of traumatic events such as

combat; more recently PTG has been identified following numerous different traumatic events suggesting that PTG is a result of the subjective experience of the event rather than the type of event (Linley & Joseph 2004). In a systematic review of 39 studies, Linley & Joseph (2004) asserted that positive change is commonly reported in around 30-70% of survivors of various traumatic events. This phenomenon will also be examined in this literature review.

The Impact of Traumatic Birth on the Woman

It is not necessarily the nature of the birth but the woman's perception of the birth, which makes it traumatic (Allen, 1998; Creedy et al., 2000; Beck, 2004a). Fear, pain, being out of control, having no say in the birth, concern for the baby and perceived poor care are some of the factors which give rise to birth trauma. This can have an impact on how a woman sees herself and her place in the world. Women may see themselves differently, a shadow of their former self, feeling they have failed at something for which their body was built. The realisation that something so appalling can happen and they cannot control it, may mean their world is no longer a safe place. Afterwards some women report feeling fear, frustration, guilt (Souza et al., 2009), anger and anxiety (Beck 2004b) and depression (Ballard et al., 1995; Beck, 2004b; Hofberg and Brockington, 2000). Some women experience flashbacks and nightmares which Beck (2004b) likens to a movie of their trauma. There may be a numbing of self, detachment (Ayers et al, 2006; Beck, 2004b) and actual dissociation (Beck 2004b).

However PTSS is not experienced by all women who experience a traumatic birth. It would be useful to compare thoughts, emotions and cognitive processing of women

who experience PTSS and those who do not. A study by Ayers (2007) examined this subject. Themes of the birth experience as one of panic, anger, thoughts of death, mental defeat and dissociation, were reported predominantly by women with PTSS. Women without PTSS reported thinking about the baby, making decisions about the labour, and reported more positive emotions in response to their own actions. After birth, women with PTSS reported more painful memories, intrusive thoughts and rumination. However women without symptoms tended to focus on the present and benefits, such as their baby, the improvement in their health and the meaning of the birth for others. The processes adopted by the women without symptoms showed a tendency to find purpose or meaning in their life. This is one of the primary strategies in the rebuilding of assumptive worlds noted by Janoff-Bulman (2004). Both groups said they tried to avoid thinking about the birth; this is noteworthy given that avoidance is normally associated as a symptom of PTSD.

Impact on the Mother-Child Relationship

Mother-infant attachment problems have been found as a result of birth trauma (Fones, 1996; Allen, 1998; Ballard et al. 1995; Beck, 2004b; Ayers et al. 2006; Soet et al. 2003; Nichols & Ayers, 2007; Souza et al. 2009). Bailham & Joseph (2003) speculate that problems with bonding may be a result of avoidance, hyper-vigilance and numbing. To the avoidant mother the child maybe a constant reminder of the trauma and may cause a re-experiencing of the event. A hyper-vigilant mother may become more anxious or irritable with her child. In the case of a mother suffering from emotional numbing a lack of interaction and emotional responsiveness to the baby could result.

In a qualitative study Ayers et al. (2006) found the mother baby bond was affected, with mothers reporting initial feelings of rejection towards the baby. Most women reported feelings for their child did develop over time, although this might have taken between one and five years, whilst a few women reported on going difficulty in the relationship. Women reported either avoidant or overprotective behaviour towards their baby. A study by Nicholls & Ayers (2007) corroborated this, reporting either an avoidant/rejecting or over-anxious/overprotecting attachment pattern.

Conversely in a quantitative study, Ayers, Wright & Wells (2007) found PTSD was not related to the quality of the other baby bond. The difference in findings may be because of the wording of the research, as the 2007 study looked at the behavioural aspects of bonding, i.e. was the baby taken care of, as opposed to the emotional aspects. Timing of the study may also have been an issue. The timing of the study was only 9 weeks after birth, where it could be argued the impact of PTSD was not yet apparent. Ayers et al (2007) also suggest the difference in results may be due to the difference in focus and levels of PTSD for the two types of study, with the qualitative study looking at clinically significant levels of PTSD and the quantitative looking at general stress responses.

In a more recent study, Elmir et al (2011) researched the experience of early mothering by women who had undergone an emergency hysterectomy following childbirth. The mothers' operation forced a separation from their babies for lengthy periods. The mothers' viewed this as a loss of precious bond forming time. The mother-baby bond suffered which caused feelings of guilt and of being a bad mother. Concern over who was looking after their baby and distress that other family members had seen and held their baby first, was also reported. Some mothers felt

guilt and a sense of failure for the perceived distress and trauma they had put their babies through. For many mothers breast feeding was seen as a way of undoing their initial failure and of acquiring the maternal role; an inability to do so because of the trauma their body has suffered was experienced as failure and shame.

The significance of breastfeeding was examined in Beck & Watson's (2008) study of the impact of trauma on breastfeeding. They found women wanted to prove themselves as mothers and atone for the baby's traumatic arrival. Successful breast feeding was healing as it helped women to regain self-esteem, confidence and restored faith in their bodies. Sadly, for other women breastfeeding was not such a positive experience. For some the physical injuries made it a painful ordeal, whilst trauma to their body sometimes resulted in insufficient milk supply. Frightening flashbacks were reported. For some women it was another invasion and violation of their body and for some breastfeeding was an empty affair which only drew attention to the detachment they felt from their babies. This detached feeling and subsequent behaviour has also been viewed in depressed women who may be less responsive, communicative and in tune their babies (Field et al, 1990).

Bowlby's attachment theory highlights the importance of mother- baby attachment for the child's development and emotional health. The literature search found gaps in research on the long term impact on children of mothers with PTSD and PTSS. However research is available for mothers with depression. The detrimental impact on the children has been noted as an increased risk of social deficits; affective disorders; behavioural problems; achievement deficits and adjustment difficulties (Anderson and Hammen, 1993; Howard, 2006; Murray et al. 1996).

Impact on the Relationship with Partner

Traumatic birth can also have an impact on the woman's relationship with her partner (Fones, 1996; Allen, 1998; Parfitt and Ayers, 2009; Nichols and Ayers, 2007). In a qualitative study by Ayers, Eagles & Waring (2006) the themes of support and strain on the relationship emerged. Even good support offered by partners was reported as just not enough to heal the distress. All participants reported strain on their relationship either as a result of loss of self-esteem because of the birth, loss of sexual intimacy, disagreements about the birth, women blaming men for the events of the birth, and women not giving partners time or attention. Conversely in a quantitative study Ayers, Wright and Wells (2007) found that PTSD symptoms were not related to the marital relationship in mothers who reported severe PTSD nine weeks after birth. However it could be that nine weeks post birth may be too short a period of time to truly measure the impact on relationships. The difference in results may be due to the difference in focus and levels of PTSD for the two types of study; with the qualitative study looking at clinically significant levels of PTSD and the quantitative looking at general stress responses (Ayers et al, 2007). One should also be careful of drawing any generalisations from qualitative studies.

Research reports sexual dysfunction had an impact on relationships (O'Driscoll, 1994; Allen, 1998; Ayers et al. 2006). Nichols & Ayers (2007) found women avoided sex because either it was a reminder of the trauma; they wanted to protect their battered body; or fear of pregnancy.

Impact on Future Childbirth

The fear of future childbirth has a huge impact on many. Hofberg and Brockington's (2000) study of women with secondary tokophobia (fear of childbirth as a result of a traumatic birth) found that when two of their participants suffered miscarriages and one an ectopic pregnancy, the women expressed enormous relief that the pregnancies did not result in delivery. The fear was so great for one woman that she underwent a termination. Nine out of eleven women in their sample arranged elective caesarean sections. This desire for elective caesarean sections as a result of previous birth trauma is corroborated in studies by Ryding (1991;1993). This obviously has a significant on-going impact on medical resources and the physical recovery of the mother. However Hofberg and Brockington (2000) found that women who received their preferred birth method fared better psychologically than those who did not.

Beck & Watson (2010) looked at subsequent childbirth following a traumatic childbirth. In a study of 35 women they found women described feelings of fear, terror anxiety, panic, dread and denial during their subsequent pregnancy. Women developed strategies such as making detailed plans to rectify things that had gone wrong previously. Three quarters of the women found a subsequent birth to be a better experience, for some it was healing and empowering; but sadly for some the second birth was not healing because it was also traumatic or because the hurt from the first birth was too huge to forget.

The potential healing nature of subsequent birth is also found in Thompson & Downe's (2010) qualitative study. The theme "Changing the future to change the past" is reflective of the redemptive, healing and transformational nature of

subsequent positive birthing experience. Thompson & Downe (2010) report that the joy experienced allowed the women to reframe and re-integrate their beliefs surrounding their birth trauma. However the trauma was forgiven rather than forgotten, as a number of women felt the trauma had still left scars. Unfortunately the story was different for women did not conceive again, unable to internalise their trauma they continued to experience a continuation of recall and flashbacks. Ayers et al.(2006) reported that women who did not conceive again experienced a sense of loss for the children they had wanted but would not have.

Post Traumatic Growth

PTG is described by Calhoun and Tedeschi (1998, 2000) as a positive change in either beliefs or functioning that can be experienced as a result of the struggle with a major loss or trauma. Their Functional Descriptive Model of PTG likens the process to that of an earthquake, with the trauma being a seismic event that threatens many of the schematic structures that have guided the individual's beliefs and actions. PTG arises from the individual's cognitive struggle to resolve this challenge to their assumptive world, which is worked through by a process of automatic then deliberate rumination. This results in a development of new schemas. Joseph & Linley's (2005) organismic valuing model of PTG is also concerned with changes in assumptive worlds but this theory has its roots in person centred theory. It argues that individuals, guided by their innate tendency towards actualization, have a basic propensity to rebuild their assumptive worlds. As such PTG is not a qualitatively different experience distinct from other normal human development but is rather a natural lifespan developmental event (Joseph & Linley, 2008).

Inherent in the concept of PTG is that individual levels of psychological development have undergone a change beyond pre-trauma levels. Therefore PTG is not the same as coping or resilience which are concerned with endurance or returning to previous levels of functioning (McGrath & Linley, 2006). Tedeschi, Park and Calhoun (1998) categorise five outcomes of PTG; increased appreciation of life; sense of new possibilities in life; increased personal strength; improvement in close relationships; and positive spiritual change.

Not everyone experiences PTG, therefore the model emphasises the importance of pre-trauma variables (such as personality and previous trauma); event related variables (for example severity) and post event variables (such as social support and amount of distress) (Sawyers et al, 2012).

The existence of PTG is not without its' detractors. McFarland & Alvaro (2000) ascertain that individuals may be motivated to cope with trauma by perceiving a personal growth that does not reflect the reality. Reporting the positive may ease some of the distress. Taylor et al. (2000) used the term *positive illusions* which may correlate to denial and longer term poor psychological outcomes. There is also considerable debate about the effectiveness of the tools used to measure PTG, as most rely on the subjective perception of growth (Ford, Tennen & Albert, 2008). However Joseph & Butler (2010) in noting the limitations of retrospection, note that positive change has been measured through other means.

Birth Trauma and PTG

My search criteria could not locate any published studies specifically examining PTG following traumatic childbirth; although Beck and Watson are currently (summer 2013) conducting a qualitative study on the subject.

My search identified two studies examining "Growth" after childbirth (Sawyers & Ayers, 2009, 2012). Whilst neither study throws much light on the link between traumatic birth and PTG (although this was not their primary aim), the second study is perhaps most useful as it found that women who had a caesarean section displayed higher levels of growth in comparison to women who had a normal vaginal delivery. The authors ascertain that obstetric intervention may be viewed as more stressful delivery experience and that the findings are therefore consistent with the view that more severe events stimulate greater growth. However there is a contradiction in that they also found participant's subjective rating of the birth as traumatic was not significantly related to growth.

There are a number of limitations to this study. Firstly the mean PTSD score after birth was low which hinders understanding of the relationship between traumatic stress symptoms and PTG. Secondly the author's analysis indicated that non respondents were more likely to have suffered from higher levels of psychological distress and therefore their sample was probably under represented by women who had found birth distressing. Finally the assessment of growth was carried out only 8 weeks after the birth which is probably too soon after the event for PTG to occur (Joseph & Linley, 2005; Tedeschi et al, 2004).

Souza et al. (2009) in a study of Maternal Near-Miss Syndrome found that despite great suffering most women managed to find something positive in the experience.

For some it was a wakeup call to who and what was important in life; to some it was a reappraisal of their relationship with God and a change to give more value to God given things rather than material possessions; the transitory nature of life had become all too obvious and for some this had a direct impact on how they took care of themselves in future. However this study was carried out before hospital discharge when the traumatic experience was still raw, it is not known whether this was long lived.

Chapter Three

Methodology

Research Philosophy and Design.

The differing philosophical views of positivism and phenomenology lead to two distinct research approaches (McLeod, 2011). Lincoln and Guba (1985) note that positivism is rooted in the belief that there is one reality; that generalisations can be made across situations and that there is a relationship between cause and effect. This positivist tradition leads to research which is deductive, theory testing and statistical (McLeod, 1999).

Qualitative research acknowledges its debt to phenomenology (Maykut and Morehouse, 1994; Loewenthal, 2007; Mintz, 2010). It is based on the perspective that all knowledge is socially constructed to some extent, that there are potentially a number of different truths and that a person's experience should be viewed holistically. This leads to a family of research methods which is exploratory and descriptive, inductive, reflexive, and to some extent, interpretative (McLeod, 1999):

> "Phenomenology is interested in elucidating both that which appears and the manner in which it appears. It studies the subjects' perspectives of their world; attempts to describe in detail the structure of the subjects' consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meanings." Kvale (1996b:53) cited in Willig (2008)

As Houser (2009) notes, the characteristics of the two approaches are almost directly opposite.

This paper's research question sought a rich in-depth understanding of how each participant gave meaning to their lived experience (Willig, 2008). This research was not seeking to quantify the frequency, consequences or cause and effect of traumatic child birth, nor did it have hypotheses to prove. The inherent nature of the research question therefore deemed quantitative research methods unsuitable. Conversely a desire to understand the essence of the participants' experience, naturally favoured the new paradigm approach which McLeod (2003) describes as a "systematic enquiry into the meanings which people employ to make sense of and guide their actions" (p.73). Thus, as Willig (2008) contends, the research title determined the research technique.

Fundamentally, the underlying philosophy of qualitative research sits more comfortably with my belief systems. There is a respect and prudence in seeking out the wholeness of the participants' experience, particularly within areas of acute sensitivity. Furthermore the collaborative nature of qualitative research promotes an understanding not only for the researcher but an illumination which is also potentially beneficial for the participant however this is not to denigrate the value or validity of the quantitative studies which have been carried out in the area of birth trauma. These studies bring to our attention the scale, causal factors and response patterns. It is hoped this research paper compliments such studies by providing a depth of understanding of the lived experience (Marrow, 2007).

Research Sample

For the purposes of my research I took the view that the birth trauma should be self-defined, reasoning this would attract diverse participation and that maximum variation sampling would offer further insight (Maykut and Moorehouse, 1994).

As my aim was to gather detailed information, purposive sampling was utilised (Smith et al, 2009; Denscombe, 2010) by selecting female, qualified counsellors who had experienced a traumatic birth and were willing to verbalize their experience. Counsellors were chosen for ethical reasons, but this type of opportunity sampling may have impacted on findings (Loewenthal, 2007). Counsellors, experienced in personal development and sharing thoughts and feelings in depth may have offered a richer depth of awareness and language than I might otherwise have encountered.

My selection criteria for inclusion were:

- women who had experienced a self-defined traumatic birth which resulted in the birth of a robust, live, child;
- who were qualified practising counsellors, qualified to a minimum of diploma level;
- who had access to supervision to ensure that they had the necessary support;
- who had access to personal counselling;
- who considered themselves to be grounded in their experience and able to discuss the impact without negative repercussions.

My exclusion criteria were:

- counsellors whose traumatic birth experience was less than 5 years ago;
- who were currently undergoing counselling as a repercussion of the trauma;
- who were pregnant ;
- who were known to me.

The criteria allowed the sample to be purposeful, but were wide enough to allow variability in factors such as age, time elapsed from the birth, cause, societal factors and experience.

In order to recruit participants, advertisements were placed with Therapy Today and BACP Research on-line noticeboards (Appendices 3 and 4). A poster was placed in local universities, colleges and 30 counselling agencies in the North West of England. Recipients were provided with a full information sheet and interview themes to ensure transparency and a pre-interview questionnaire to ensure participants met the required criteria (Willig, 2008; Denscombe, 2010) (Appendices 5,6,7). In order to add to triangulation, participants were invited to bring any diaries, poetry, photographs or items which could enlighten their experience.

The planned sample size was between four and six participants; a practical consideration given the timescale as a larger sample size might have hindered my ability to fully immerse myself in the experience of my participants. In the event, response to my initial advertisements was slow, transcription took longer than

anticipated and the sheer amount of data could have become overwhelming (Smith et al. 2009). I therefore stopped recruiting when I had four participants. In order that I did not succumb to bias the first four people who met the selection criteria were chosen as participants.

Data Collection

In line with my research philosophy and phenomenological approach, I decided to use semi-structured face- to- face taped interviews as a data collection method. I had given consideration to other methods such as structured and unstructured interviews, focus groups and narrative/life history (Hart, 2005). However I favoured this exploratory nature of questioning of open ended questions, which gave focus but also allowed the participants some freedom to refer to aspects of their experience which I may not have previously considered (Timulak, 2005). I sensed the close interaction gained with my participants from a semi-structured interview could provide the in-depth holistic understanding which I was seeking (Faber, 2006).

The use of semi-structured interviews has produced debate. Potter and Hepburn (2005) cited in Willig (2008) ascertain that analysis of semi-structured interviews shows a failure to pay attention to any contextual features of the interview. Instead, data is taken at face value. Davies (2007) notes the reliance on the researcher's interview skills and McLeod (2003) warns that the interviewer's personality might be influential; I hoped that thorough planning would mediate these shortcomings.

Any research method has practical disadvantages. Thought was given to the expense in both time and travel; the rigours of transcription; the potentially

intimidating nature of tape recording; the need to make adequate safety precautions; and the need to improve my own interview skills (McLeod, 2003; Smith et al. 2003).

In preparation for the participant interviews, a trial interview with a colleague was conducted. The trial highlighted a need for greater probing and clarification. The interview ran slightly short of the hour, providing confidence that there was time for more elaboration in the participant interviews.

All interviews were conducted in a safe, confidential environment. Once the taped interviews were transcribed, I offered the participants the opportunity to review the transcript, make appropriate amendments and satisfy themselves of anonymity.

Data Analysis

Within the phenomenological approach to data analysis I was drawn to the interpretative stance as opposed to the traditional descriptive approach which is largely based on the work of Husserl. Whereas descriptive phenomenology talks of themes emerging, interpretative phenomenology recognises the more active role the researcher may have in bringing themes to light (Pringle et al, 2011). It is arguable whether it is possible to be descriptive without being interpretative. For whilst Husserl espoused the term “bracketing” to describe the process of phenomenological epoch, Heidegger demonstrated that all description is interpretative; there is no way of arriving at a pure description (Langdridge, 2007). As Agar observes, “the problem is not whether (the researcher) is biased, the problem is what kind of biases exist” (1980:42). I was persuaded by the interpretative argument, whilst keen to ensure the foundations of description remained in place.

I chose Interpretative Phenomenological Analysis (IPA) as my method of data analysis; it is consistent with my research quest to uncover my participants experience and understand how they made sense of it. IPA is indebted to the hermeneutic tradition; it argues that the description of the phenomena is a form of interpretation as it is filtered through our historical context and language and will therefore inevitably influence any interpretation (Willig, 2008; McLeod, 2003). It therefore accepts that any analysis produced by the researcher is always an interpretation of the participants' experience (Willig, 2008). Smith & Osborn, 2003, argue that IPA involves a double hermeneutic, in that the researcher is making sense of the participant, who is making sense of his/her experience. Pringle (2011) points out that the level of interpretation in IPA is different from "interpretation of suspicion" or critical analysis but is rather an interpretation rooted firmly in what the participants are saying.

IPA is systematic and rigorous in nature. It works on texts generated by the participants, with the researcher becoming immersed in each text. The approach is idiographic; each text is analysed individually, broken down into component meanings, which are then progressively integrated into higher order units, before looking for commonalities across all texts (Willig, 2008).

On completion of the verbatim transcription of the individual tape (Appendix 8), I played the tape in its entirety whilst reading the transcript. I immersed myself by reading and re-reading, making notes in the right hand margins of the transcriptions of whatever thoughts came to mind and my sense of what was being expressed. I then looked for themes in each section of interview which I were noted on the left

hand margin of the texts (Appendix 9). Once complete these emergent themes, the page number, line number and a summary of what was said were electronically tabled (Appendix 10). The themes were then clustered into superordinate themes (Smith et al, 2009) (Appendices 11,12). The cyclical nature of the process became apparent as I constantly questioned whether my interpretation was representative of the original interview by returning time and time again to the text (Willig, 2008).

In line with the idiographic approach it was only when one text was analysed that the next text was considered. Despite planning in an interval between texts in order to clear thoughts of the previous transcript, the practical difficulty of bracketing personal history and information gained from previous transcripts was encountered. Smith et al.'s (2009) suggestion of keeping a journal of thoughts of previous participants' stories and personal memories and assumptions was therefore adopted (Appendix 13).

Once all texts were analysed, superordinate themes were integrated into master themes and sub-themes by the comparison of all texts (See Chapter 4). Each sub-theme was electronically tabled separately for ease of inclusion in the report (Appendix 14). This process sounds very prescriptive, but in fact, it became apparent that some themes could fit into a number of superordinate themes and there was a considerable amount of sorting and movement and consequently the need to visit and re-visit the original text.

I am aware that recent researchers have added a further level of interpretation which critically interrogates the participants' accounts and takes the researcher beyond the participants' own words and understanding. This obviously has ethical implications

around the imposition of meaning and the giving or denying of a voice to research participants (Willig 2008). Uncomfortable with this, my analysis has not taken on this level of interpretation.

Ethical issues

Ethical approval was obtained from the University of Chester prior to commencement of the research. My research was carried out in line with the BACP ethical guidelines of beneficence, nonmaleficence, autonomy and fidelity (BACP Ethical Framework, Bond, 2004) and the University of Chester's Research Governance (2012). Hart (2005) points out that ethical issues have to be considered throughout all stages of research, from design to reporting. Full details of ethical considerations at the design stage are found in Appendix 15.

Given the sensitivity of this research, the ethical principle of nonmaleficence was uppermost in my mind. Paradoxically, this study does meet the ethical principle of beneficence, as recollection has had positive and even therapeutic effects for the participants (Smith, 1993; Rennie, 1994; Beck 2004b). Willig (2008) notes the importance to reflect on the meaning and experience of the interview for both participants. I conducted a short debrief at the end of the interview. All spoke of how helpful it was to have shared their story in its entirety, for some, for the first time.

Bond (2004) highlights the need to have a responsibility to self. I was aware that there were potential risks to my own wellbeing in carrying out this research. I felt grounded in my experience, but as an additional precaution, I sought personal counselling prior to starting any of the interviews. I found this a positive experience. I

have continued this self-care by seeking the support of my counselling supervisor throughout the process. This has been beneficial as I have felt moved and honoured in listening to my participants' stories and I have certainly grappled with a cauldron of emotions the research has produced.

Informed consent falls into the ethical principal of autonomy. In order to gain informed consent, I gave my participants written statements detailing the research aims, procedures, potential risks, complaints procedures and their right to withdraw from the research at any time (Bond, 2004) (Appendix 16,17). I was mindful of the sensitivity of this research and aware that participants may change their mind at any point during the process. I followed Munhall's (1988) suggestion of "process consenting"; that is seeking consent on an on-going basis by highlighting the right to withdraw prior and post interview, and by offering the candidates the right to review the transcript and findings.

All interviews took place in a safe and secure environment. Confidentiality was protected by use of pseudonyms, and the normal care and attention given to the confidentiality of data as stipulated by my counselling practice and the data Protection Act.

Validity and Trustworthiness

Willig (2008) defines validity as "the extent to which our research describes, measures or explains what it aims to describe, measure or explain" (p16). Whilst standard criteria can be applied to quantitative research (McLeod 2011), the same criteria cannot be used to validate qualitative work, where the aim is to explore rather

than measure. Therefore a different set of criteria is needed to prove the validity of a qualitative study. Maykut and Morehouse (1994) and Lincoln and Guba (1985) see trustworthiness as the basis for validity in qualitative work, with McLeod citing trustworthiness and plausibility (2011). However the trustworthiness of qualitative research is complex and can be described slightly differently by different authors (Mintz, 2010). Given the diverse nature of qualitative methodologies, it follows that any measure of validity will likewise need to be diverse and methodologically appropriate (Yardley, 2000).

An additional complication in IPA is that the analysis is, by its very nature, an interpretation by the researcher. This may lead to questions of the validity of the findings. Smith et al (2009) argue that validity criteria should ensure the account produced is a credible one, not the only credible one. Yardley (2000) suggests four broad principles to ensure validity and Smith et al (2009) have suggested ways in which IPA can meet these criteria. These principles have been applied to this piece of research as shown below.

1. Sensitivity to Context.

This research topic explores an emotional, perhaps painful subject. The choice of a methodology which looks at the individual's story in its entirety shows a respect and sensitivity to this fact. Throughout the research, consideration was given to the balance of the requirements of research with the knowledge that participants had suffered a terrible ordeal which may have had a profound affect on their life. The careful literature research, the consideration given to ethics, the provision of the core conditions of empathy, UPR and congruence in all of my contact with the

participants, and interpretation which is offered cautiously are all demonstrations of sensitivity to the subject.

2. Commitment and Rigour

As there is an overlap between sensitivity and commitment, much said above also demonstrates commitment to this research. The rigourous nature of this study is demonstrated by the comprehensive audit trail provided, robust enough to allow replication (Maykut and Morehouse, 1994: Smith et al, 2009). Meticulous and equal attention has been given to each participant in preparation, interview and analysis. Triangulation in the form of a thorough literature review, member checking and the request to participants to bring meaningful belongings ensured further rigour (Casey and Murphy, 2009; Hart 2005; Maykut and Moorehouse, 1994).

3. Transparency and Cohesion.

The detailed and transparent account of process and analysis provided illustrates the cohesion between all stages from initial philosophy to final analysis. Transparency is also displayed in the inclusion of the researcher's reflexive journal, for whilst IPA acknowledges researcher influence, it is important to reflect on their role and impact on the findings (Willig, 2008).

4. Impact and Importance.

Langdridge (2007) acknowledging that the research should have an impact on someone other than the researcher refutes the stance that research validity should be based on its impact on the world. Meanwhile Wosket (1999) talks of micro validity; certainly this research has enhanced the researcher's counselling practice resulting in direct benefit to clients (Appendix 13). Hopefully this research will resonate with

other counsellors and medical professionals, who may reflect on it to help them in their work with women who have suffered a traumatic birth.

Limitations

There are limitations to this research which is general to all phenomenological studies. It is a small scale study, of self-defined experiences from women from a similar geographical area. Malim et al (1992) argue IPA studies have the potential to be subjective, intuitive and impressionistic. IPA recognises that understanding requires interpretation which could mean that another researcher would interpret the data differently. And whilst reflexivity will moderate interpretation, it would be impossible to remove it completely. Some will still view these points as researcher bias (Willig 2008).

Denzin and Lincoln (2005) highlight that the success of interviews is dependent on the participant's ability to report on their experience. And there will always be questions about the reliability of using participant's retrospective recollections. Furthermore Parahoo (1997) regards volunteer sampling as weak, as participants are motivated to volunteer for some reason and this should be acknowledged as a potential sampling bias.

In order to ensure ethical practice, participants were qualified counsellors whose training necessitates personal development. They may have worked through their traumatic birth and be in a very different place to women who have never had the opportunity to explore their experience. Participants were also at least 15 years post-trauma and again could be in a different place from mothers who have experienced

the trauma more recently. However phenomenologically this does not invalidate its meaning.

The interview process produced rich information. But after the initial analysis it would have been beneficial to return to the participants for further illumination. However, constraints of time and word count made this impractical (Hart, 2005; Denzin and Lincoln, 2005). My own limitations as a novice researcher have also impacted on the study in both interview technique and final analysis. This is demonstrated by my choice of interview questions, which ultimately influenced the outcomes of this research. An alternative might have been an unstructured interview, however, analysis of such may have been too difficult for a novice researcher.

Chapter Four

Findings

Participant Profile

Purposive sampling was used to recruit the four participants in this research. In order to protect anonymity, pseudonyms have been used.

All participants experienced a self-defined traumatic birth and gave birth to a robust baby. All women were of white British descent. At the time of the study all women were aged in their mid to late forties. The interval between their traumatic birth and this study was between 15-25 years.

Three women experienced assisted vaginal deliveries (ventouse and/or forceps), with tearing and/or episiotomies requiring stitches. Two of the three women have experienced on-going physical repercussions. For one participant the trauma occurred immediately post-partum in the form of a potentially life threatening condition resulting in a 6 weeks recovery period.

This was the first child for all participants. Two women went on to have one more child, both with a five year gap between children (Joanne and Diane). Both of these second births were difficult, with Diane describing her second birth as traumatic too. One woman (Alex) had two further children, both births contained considerable risk and difficulty, although she did not categorise them as traumatic. One woman (Sandy) went on to have three more children and all were uncomplicated births.

Identification of Themes

After analysing the data using IPA methodology outlined by Smith et al. (2009) the following super-ordinate themes and sub-themes were identified.

Focus on Processing the Trauma
Dissociation as a Coping Mechanism
The Baby as the Meaning Maker
Keeping Quiet and Trying to Cope
Working through Depression
Putting the Bad to Good Use.

Focus on the Sense of Self
Loss
Seeking Redemption
Reassertion
Post Traumatic Growth

Focus on Family Relationships
Impact on the Marital Relationship
Impact on the Mother-Baby Relationship
Impact on Future Pregnancies

Theme 1: Focus on Processing the Trauma

1.1 Dissociation as a Coping Mechanism

Whilst all women experience pain, fear and loss of control, three of the four women described their birth trauma in relatively factual as opposed to emotional terms. These women also showed dissociation at the time of the trauma. Emotionally they had removed themselves to a safer place.

Alex:

> *"I felt like I was floating somewhere else" p3, 37*

"I felt like it wasn't happening to me. Like it was really happening to someone else. And yet I knew exactly what was going on" p5, 16

Diane:

"*I was worried and everything but I was more in a bubble than anything, I don't think it was impacting on me as I would have expected."* p1, 30

"I can see myself in that situation but it was almost like I was observing what was going on rather than so much experiencing it, you know." p14, 33

Joanne could not recall her feelings at the time of the trauma:

"I can't remember because I squidged it out" p13,1.

In contrast Sandy described her traumatic birth with great emotion. She did not mention dissociative indicators:

"It's scary. I think it's the scariness of it, not being in control, not knowing what to do, not being listened to, not being helped, not being understood" p,22,14.

"That pain I will never forget it ever, ever" p3, 32.

"If I could erase it from my mind I would really like to" p17, 8.

1.2 The Baby as the Meaning Maker

The delivery of a healthy baby was central to their processing and the sense making of their experience. In the immediate aftermath of the trauma, some of the women described concentrating on the needs of the baby rather than ruminating on their own misfortune.

As a potentially life threatening condition developed in her body, Alex recalls the focus was on taking care of her baby:

> *"And all I could think of was "I haven't fed this baby properly and I was focused on that. I must feed this baby." p4, 23*

For Alex the trauma was not forgotten but it was pushed to the background:

> *"I was certainly aware that, all of a sudden, I had gone through a massive trauma, and this massive life event, and yet I still had this baby. I had to look after her." p* 6, 23

Diane's account was similar:

> *"And then he was born and you have a baby then haven't you. I had to stay in hospital for about 6 days. And he was a bit jaundiced. So I think straight after the birth I was more focused on him." p2, 38*

Joanne seemed to find meaning by balancing the trauma against the outcome of a healthy baby:

> *"I was upset that it had happened but okay because my baby was strong and well."* p5, 24
>
> *"So I think the saving grace through all of it was that she was totally okay.*" p6, 11

For Sandy her baby provided all the meaning she needed, she could concentrate on the positive and he became her healing agent:

> *"Giving birth is not easy and mine was particularly traumatic but you come out with something at the end. With a lot of other traumas, like soldiers coming back from Afghanistan without limbs, they have not got anything to show for their trauma, they have had things taken away from them. Whereas the difference with a birth and giving birth to a baby that's perfectly healthy, at least you have got that baby to help the wounds heal I think." Sandy p21, l7*

Sandy movingly affirmed that despite everything:

> *"I still managed to give birth to a perfectly healthy baby boy, so I think that's what heals. It's him" p21, 29*

1.3 Keeping Quiet and Trying to Cope

In the aftermath of the trauma none of the participants talked to anybody, neither family, friends nor professionals, about their experience and how it had left them feeling. Their process was to keep quiet, suppress emotions and try to cope. Rumination was not part of their process at this stage.

For Alex it appeared safer to keep quiet, than to face what had happened:

> *"I don't think I had quite worked out what was happening to me. I don't think I quite knew. I couldn't articulate it to myself. You know that fear, that "Oh God, I could have died" and "This wasn't quite perfect". I don't think I had quite processed it. I wouldn't have known what to say to people." p15, 2*.
>
> *"I think I was downplaying it to myself to survive and underplaying it to people actually. Because if I really admitted how awful it was I might suddenly feel it" p37, 32*

Joanne was silent and suppressed her emotions by keeping busy:

> *"The coping was suppressing the emotions. I literally put a lid on it, you don't go there. And so I just went into the practical side of caring for a new baby and doing as much as I could and gradually building it back up and putting up with the discomfort and pain." p13, 8*

Diane described how she coped in the aftermath:

> *"You pick yourself up, you get on with life. I don't think I ever really talked about what it was like. P10, 16*

"It is an experience that has been boxed off."19, 7

Diane's silence was so contained that even her husband was unaware that she felt her birth was traumatic:

> *"When I said to my husband that I was going to do this* (the research into the impact of traumatic birth), *he said to me is that a traumatic birth?" p10, 18.*

Sandy also decided to seal the experience away:

"I didn't talk about the labour" p14, 23.

"I've never told anyone how I felt" p14, 25

"I think I shut it away in a little box." p14, 12

1.4 Working through Depression

All the women experienced what they now term as depression, although they may not have recognised it at the time. For Diane the depression emerged as she returned home following the birth. For Alex and Joanne depression occurred after later births, although both attribute it to their earlier birth trauma. Sandy's experience was different as whilst she suffered from PND after the birth of her last child, she believes this was a hormone imbalance rather than a belated repercussion of her trauma.

Alex, Joanne and Diane sought different methods of support to work through their depression.

After her third birth, which was difficult if not perilous and traumatic, Alex described her feelings as:

> *"I just remember suddenly feeling this awful panic and felt clammy and just thinking "oh it's not fair, it's just not fair". And just feeling really, really low for about 8 weeks. So low I couldn't, didn't want to go out. I had got through the other two quite stoically but with this one I didn't have anything left."* p10, 27

Having the support of her husband, mother and a close friend she felt held enough to explore and ruminate on herself and this new murky world:

> *"I'd gone right down but I thought you know what, I am okay. I'm still here. And this is about as bad as it could have got. I can do this. I can even do this misery. If it carries on I can do it. And that for me was like feeling the pain and doing it anyway. And realising what my boundaries, you know I touched my edges and I was okay. I'd stopped frightening myself. I worked out that I was able and I was strong. What I was able to cope with. I sort of processed the fear." p25, 16*

Joanne recollects little of her depression but remembers a number of factors which combined to threaten her resilience, resulting in:

> *"I was finding it difficult to cope. I think deep down it was the trauma coming out"* p10, 13

Joanne sought medical help and was referred to a psychologist for hypnosis.

Diane described her depression:

> *"If I had had a couple of days which were good I would think oh something is going to happen now, you know. Tiredness and lack of motivation, I think that was the main thing and just not being able to keep on top of everything; everything seemed to pile up. Everything seemed an effort."p8, 17*

Diane attended a support group to help a friend but found it valuable for her own process of making sense of her feelings:

"I never even considered it was depression. I was going to a support group and any arguments I had with my husband or anything I would say oh horrible day today, tell everybody about it you know and apply the 12 step programme to it. I was very, very lucky", p15, 27

1.5 Putting a Bad Experience to Good Use

The ability to help others brought some meaning to their traumatic experience.

Alex recounted how her decision to become a counsellor was a direct result of her experience:

"So that really helped to shape me wanting to get into counselling. Also what isn't okay to say, when people say the wrong things. How damaging that is, I know that. I've learnt what not to do, what not to say. I think I'm pretty bloody good at helping people now because I have been there" p30, 20

Joanne described a similar desire. In her case she has developed an affinity to working with women:

"I realised that it (counselling) brought everything together, it was basically what I wanted to do, to help people get over things" p26, 11.

"Some energy is out there that I would rather work with women and actually I now specifically state I work with women" p27, 1.

Sandy explained her motivation for agreeing to this research:

""If I can help I will talk my heart out" p19, 7.

Theme 2: Impact on Sense of Self

2.1 Loss

All women experienced a sense of loss because of the nature of the birth and its' aftermath. This was more than a grieving for a beautiful reaffirming birth experience. This was a sense that part of their very being had been lost too.

Alex suffered PND and describes the shock in facing up to her new self:

> *"Oh my God, I can't believe I was anxious, I'm not an anxious person! I've never experienced anything like that before, you know. I coped. I don't do depression. You know I'm not really the anxious type. You know I'm dead healthy. You know. Well rounded. You Know. That was my self-image. Not exactly invulnerable but strong. I've got a lovely family. I'm not going to get things like that. Nothing awful has really happened to me. So I think in the first year after my baby was born I had to re-evaluate who I was." 20, 35*

Five years after the birth, a series of factors culmination in a referral to a psychologist. Joanne explained how she now viewed herself:

> *"Its failure, you failed to have a normal birth and you have failed to be the perfect Mum and you failed this and you failed that , you are not good enough" p29,30.*

In addition to her sense of failure Joanne also described a detachment and loss from her womanhood:

> *"I associate sex with pain and the pelvic area with pain and discomfort" p22, 32*

> *"I was denying parts of myself. I was denying my womb space really because the whole thing, you know the woman thing, has just got pain associated with it" p24, 5*

Some twenty years after the birth, Joanne recently attended a retreat and:

> *"I am now looking at my sort of pelvic area in a different light now and actually healing it" p23, 5*
>
> And
>
> *"It's amazing, that psychological reprogramming to honour that part of her womanhood if you like which I have denied" p23, 13*

Sandy revealed an utter sense utter sense of shock in their inability to control either her own body or the circumstances of the birth. She too saw herself as a failure.

> *"My first birth was completely out of control, I wasn't in control, you've never done it before, you don't know what to expect but I was not expecting not to be able to catch my breath, not to be able to do it. I suppose I was almost annoyed with myself that thousands of others can. What is wrong with me, why can't I do this, lots of people can, why can't I?" p*9, 21

A theme that Sandy returned to on three occasions was that during her traumatic birth nobody seemed to listen to her, that she was not important. The traumatic nature of the birth and her treatment shook her confidence in the safety of the world and her place in it:

> *"It was as if I didn't matter. And that was scary. It's the first time I have ever felt like that. It just felt like I was the vessel and the baby was the most important thing, you know bringing this child into the world healthy which was the main thing which of course it is. But at what cost? At what cost?" p13, 1*

2.2 Seeking Redemption

All four women breast fed their babies, although their physical condition made this difficult. This seemed to fulfil a number of functions for whilst it gave their baby the best start in life, it also helped re-establish some control and claw back some self-

esteem and sense of normality. There was a redemptive element in this breastfeeding, as it asserted their status as successful nurturing mothers.

Alex:

> *"I had all the obstacles (for breastfeeding), mastitis, terrible mastalgia, you know really painful feeding. And I still kept going. I couldn't control anything else and I was so out of control with everything else. I had no control over my childbirths. It was the one thing I could do" 19, 29*

Joanne:

> *"I needed the control and to get back, be normal", p7, 22*

> *"I was limited in what I could do. Just lying there and feeding my baby, in I was doing something I could do" p9, 26*

Sandy:

> *"I was going to breastfeed yeah, I wanted to be a real mum a proper mum" p11, 5*

Diane:

> *"I would have been really devastated if I couldn't have breast fed" p7, 14*

> It was important "*in getting close to your baby and nurturing your baby*" *p7, 18*

2.3 Reassertion

Joanne, Sandy and Diane believed they had put themselves in the hands of experts, had been too compliant and had been let down. Armed with a better understanding of their body in labour, they resolved not to allow this to happen for their second birth. The second births demonstrated an internal locus of evaluation not apparent in their first births.

Talking of her preparation for her second birth Sandy said:

> "I*t gave me the strength to go into my later labours knowing that I wouldn't just leave myself in their hands again, I wouldn't take their word for what was going on all the time. I wouldn't just accept what people say anymore. I would question it*" p17, 27
>
> "*I would not be a martyr" p15, 25*
>
> *"So I put myself in control."* P15, 29

On being advised that her second baby might need to be induced Joanne was able to assert herself and take more control of her pain relief:

> "*I was quite happy to scream I want the epidural now! They didn't catheterise me so much because I was able to explain and they were really understanding*." p14, 16

Diane's explained her view of herself in her first birth:

> "*I was like a frightened rabbit the first time" p18, 25.*

In preparation for her second birth she decided:

> *"I am going to be able to express myself and say what I need."* p18, 26

In actuality she did listen to her internal locus of evaluation. During her second labour the hospital wanted to send her home deeming she was not yet in labour, whilst she believed she was:

> *"But I didn't go because I knew I could feel my body and I knew what was happening and even if there were authoritative people who were saying no you're not, I was more assertive and said no.*" p17, 32

2.4 Post-Traumatic Growth

Three participants believed their trauma had resulted in post-traumatic growth. However this is not to say that their suffering and their journey was forgotten or forgiven. Nor that the growth compensates for the suffering encountered. A number of the women commented on the duality of their journey.

Alex explained an increased awareness of self:

"*I knew where my edges were. Knowing that I could go quite a long way out of my things going wrong range. I could go way out. They could all go horribly wrong and I wasn't going to disintegrate. I nearly did but I didn't." P30, 18*

And

"It's made me nicer. Probably a bit easier to be with. And it has made it easier for people to be vulnerable with me. More open to I think. Softer." P30, 29.

But

"*I have regret for that peri-natal period. I would have liked to enjoy them more as babies and I feel sad that I didn't"* p32,

And

"It traumatized me and the effects have stayed with me ever since. Good and bad. Since then I've been more easily triggered in anxiety provoking situations" p39, 22

Diane:

"I think it was a strength that I felt more at one with myself, you know that I was able and capable." P17, 25

"*I think it certainly helped me develop as a person" p13, 25*

But sadly:

"Not wanting any more children, that is probably the most dramatic impact (of the traumatic birth)." p13, 33

Joanne:

"It has made me who I am, it has made me stronger in some ways" p22, 7

"It gave me some belief in myself. You know if you can get through this you can get through anything" p31, 6

But Joanne also tragically experienced on going

"guilt that my daughter thought I blamed her for my medical problems." P11, 40

Sandy felt differently. Whilst she recognised she was more assertive in her later births, she saw this as a particular circumstance and did not relate this to growth. She was vehement that:

"*Nothing good came out of that labour. Only my baby*" p17, 6

Theme 3: Focus on Family Relationships

3.1 Impact on the Marital Relationship

The birth trauma had an impact on marital relationships. Sandy and Diane felt very let down by their husbands for not protecting them during their birth trauma. Experiencing anger and hurt they took refuge in their baby, pushing their husband aside. This anger had been forgotten over time but their reaction in recalling this was very emotional.

Sandy:

> *"I would look at my husband when I was going through this as if to say please save me, do something." p13,17.*

> And *"I did hold it against him for not sticking up for me. I remember us having a row and me saying you never fight my corner, you weren't there for me in that labour. And that really hurt him" p18, 10.*

> *"I probably did shut him (her husband) out a bit because he (her baby) was mine and I was not sharing. You have no idea what I went through to get this child, he is all mine" p11, 29.*

Diane talked not only of her anger but of how the birth had not been the unifying experience she had anticipated:

> *"I was angry with him that he wasn't more in control of the situation. It was like you know you were supposed to be looking after me and all this went on." p10, 4*

> *"He was part of the birth but wasn't." p9, 16*

> *"There was a definitely a dramatic effect on our relationship but I felt that my husband had been very much babied by me, when I was giving my attention to a baby he was sort of like whoah." p12, 34*

Conversely Alex and Joanne both felt supported:

Joanne talked of support and protection:

> *"There is relief that he had been there supporting me but also guilt that he had to see me go through that. After the birth of our second child he was adamant*

that we were not going through that again. He was not putting me through that again" p 19, 30

Alex described their relationship as she suffered the depths of depression following her third birth:

"*I said I can't cope. So he had to." p27, 32*

"I always knew he was solid and there for me. So I think I recognised how strong he was. And then I think that when I started to recover myself, he recognised my strength as well." p28, 3

"There were loads of stresses in our relationship that had come in but ultimately it brought up closer together. You know we were, we took over when each one needed it." Alex, p27, 35

3.2 Impact on the Mother- Baby Relationship

Bonding with their baby was a source of discussion for all participants. Only one participant, Sandy, felt an instant love and adoration. This love was all consuming.

Sandy:

"I really went into mom mode. I would lose days because I would just sit in pjs with my baby, just me and him. It was gorgeous, it was great." p11, 7

"It became all encompassing. I couldn't leave my baby with even my husband on his own, he was mine, it was really all on." p21, 4

For the other participants there appears to be something missing from the early description of motherhood. Two of the participants show this in their hesitancy in their description of bonding.

Joanne:

> *"It probably did effect the bonding, probably more than I give it credit for or actually would care to remember" p16, 23*

Diane seemed unsure and raised the issue of difficulty in breastfeeding, suggesting it may have had an impact on that initial bond:

> *"I think I bonded well with my son" 6, 32.* But

> *"I didn't think what a gorgeous baby or anything. We did have difficulty with breastfeeding at first" p6, 38*

Alex was very clear about how she bonded with all three of her children. On her first child following her birth trauma, she recalls:

> *"I didn't really bond. I just stared at this child and remember thinking, I can't manage this." p5, 10*

Alex thought the impact of her trauma materialised after her third birth. She did not initially bond with her baby. And then:

> *"I just remember feeling a rush of love. I just remember going Oh my God I love you. I'm so,. and I was thinking why did I have this third baby up until then. And then I realised, I do want her," P19, 28*

Feeling guilty for not initially bonding and trying to compensate for her depression:

> *"I held her all the time, I didn't put her down for those weeks. I think I felt bad for how numb I was, how anxious I was. I held her all the time. I fed her all the time. I wouldn't let her out of my sight" P 19, 31*

3.3 The Impact on Future Pregnancies

The trauma left all women very fearful of future pregnancies but this was overridden by the desire for a family and a common belief that it could not happen again. Happily a redemptive birth gave Sandy the confidence to go on to have the large family she longed for.

Sandy:

> *"Well I sort of reconciled myself to the fact that it couldn't be any worse and I felt everything that could go wrong had gone wrong" p7,19*
>
> *"But every now and again, the first birth would come back to haunt me. As I entered hospital to have (second child) I was as sick as a dog through nerves" p8, 28*
>
> *"She was a darling (her second baby), she was seven pounds wet through, 2 hour labour, I could never thank her enough" 6, 13*

Sadly for Joanne and Diane difficult second births brought their childbearing years to a premature end.

Joanne:

> *"There was fear of going through it again but it also felt right having a second child and the thought that it is not going to happen twice like that." p19,16*

Her second birth was problematic and the decision was made that Joanne's husband would be sterilised.

> *"It wasn't worth the risk of me getting pregnant again" Joanne, p19, 8*

Physical and psychological injuries from Diane's first birth impacted on her readiness to have another child:

> *"I had a lot of stitches and things, so physically I was not going to go for another baby very quickly. And also because of the depression afterwards. I think it was a long time before one, I thought I could go through birth again and two that I could cope with another baby again*." p3, 33

> *"I thought the second one is not going to be as bad*", p12, 9

After a traumatic second birth, Diane decided:

> *"this is not happening ever again. A few years later my husband said it would be nice to have another baby and I said no thanks. Oh no I wouldn't put myself through that again.*" p12, 12

For Diane the premature end of her childbearing years was the most significant impact of her birth trauma:

> *"Not wanting any more children, that is probably the most dramatic impact* (of the traumatic birth)." p13, 33

This section presented the findings. The next Chapter will feature a discussion on the findings and position them in relation to other research.

Chapter Five

Discussion

This phenomenological study exploring the impact of traumatic birth identified three master themes: Processing the Trauma; Sense of Self; and Family Relationships. There is considerable overlap in these areas, with one often impacting on the other. For example the subordinate theme post traumatic growth could arguably have been categorised within processing the trauma theme. However, as three of my participants tended to talk of PTG in terms of their sense of self as opposed to the process of how they gained that growth, it seemed more appropriate to categorise it as such.

The first category identified the women's process and sense making of the trauma. All women described emotions of pain, fear, powerlessness and loss of control during the birth. Three of the women described their reaction to the unfolding trauma itself as one of dissociation:

"I felt like it wasn't happening to me. Like it was really happening to someone else." Alex, p5.

Dissociation at the time of the birth shielded them from a horrific reality. Dissociation is a controversial subject. It can be seen as a normal protective process, whereby a person disconnects from parts of an experience in order to prevent being overwhelmed (Etherington, 2003) or as Nijenhuis et al (2001) suggest a failure of the normal integrative mental process (cited in Olde et al, 2008). But dissociation is not a perfect answer and may have negative side effects, for example nightmares, flashbacks or emotional numbing (Etherington, 2003). This numbing effect was

experienced by Diane (17, 3), who noted how she spoke of her birth very factually, almost as if there was no emotional involvement there. The existence of negative emotions and dissociation in childbirth in this study correlates with other research (Olde et al, 2006; Creedy et al, 2000; Ayers, 2007).

The safe arrival of their baby was a major part of the sense making of for all mothers. Mothers showed concern for the safety of their baby during the birth trauma and afterwards they focused on the baby rather than their own emotional and physical health. This focus was there irrespective of whether they felt an immediate bond with their baby or not. For Sandy her baby was very clearly the meaning maker of her trauma, she made the point no matter how bad the birth was, no matter how much of a failure she had been, she had still given birth to a healthy baby who had healed her. She poignantly compared her birth trauma to military amputees, making the point that ultimately she had gained where they had only lost. Tennen & Affleck (2002) (cited in Park, 2010) view this focus on the positive outcome as a meaning-making coping strategy, which in effect modifies the meaning of the trauma. The same type of cognitive processing was found in a study by Ayers (2007), where women retrospectively gave a more positive meaning to the experience by focusing on the baby. Ayers (2007) proposes this process suggests all was worthwhile. However Sandy's vehement assertion that nothing good came out of the trauma bar her son, highlights the complexity of this. The birth may well have been worthwhile but that does not mean it was forgiven.

Beck's (2004b) study of PTSD following a birth trauma, found her participants wanted to talk, talk, talk! A study of Brazilian women who experienced perilous births, found

the women ruminating on the events (Souza et al, 2009). Conversely, a study by Ayers' (2007) which compared women who had PTSS with those who did not, found neither group wanted to think about their trauma. The initial process of the women in this study was neither to think about nor talk about their birth. Two participants did not even share their thoughts with their husbands. So effective was Diane's secrecy that it was only when she announced she was to take part in this research, that her husband realised she had felt her birth was traumatic. This lack of communication between partners about the trauma was also noted in a Nichols & Ayers study (2007).

Silence does have the potential to isolate and both Alex and Joanne said their social group of other mothers decreased in size. This could be detrimental when the company of other mothers can provide much support.

The participants gave a complex web of reasons for the silence, for example it was their personality type to accept the cards dealt; the desire to put a lid on things and get on with it; the fear that people would not want to know; the fear that other people would not understand; that it might frighten others, especially mothers to be; and that they did not want to upset those close to them. These could be avoidant strategies but it was only Alex who disclosed it as such:

"I think I was downplaying it to myself to survive and underplaying it to people actually. Because if I really admitted how awful it was I might suddenly feel it" p37, 32

All participants' birth traumas took place over fifteen years ago, but the research interview was the first time any of the women had ever talked about it in any detail. Following the interview all mentioned how good and therapeutic it had been to talk at last. Whilst it is outside of the scope of this research, it seems plausible that the

anonymity of today's social media and the advent of sites discussing birth trauma may make it easier for women to discuss their experiences without the fear of upsetting others or not being understood, factors which silenced some of this study's participants.

Research by Czarnocka & Slade (2000) found that six out of eight women who met full DSM-IV criteria for PTSD and also had also scored 13 or more for probable major depression on the Edinburgh Postnatal Depression Scale (EPDS). In studies of the PND in the general female population, Gavin et al (2005) found 21% prevalence (cited in Wylie et al, 2011). All four of the women in this study experienced depression, with three directly relating it to their birth trauma. Whilst this qualitative study cannot be generalised, the high incidence of depression in this study is worthy of note. It is a sad statistic that self-harm is the main cause of maternal death in the first year post-partum (Wylie et al, 2011), and if birth trauma is risk factor for depression, it should be noted by caregivers.

Symptoms of PND and PTSD have some commonalities, for example sleep disturbance, trouble concentrating, avoidance, anger, guilt, shame. This brings into question the likelihood that some women will be misdiagnosed with PND, the more familiar condition, when PTSD may be more appropriate (White et al, 2006). Interestingly the participants to this study did not label their emotions or physiological symptoms as PTS, but they did equate them to depression.

The mothers in this research worked through their depression in different ways, a support group (Diane), family support and rumination (Alex), and hypnosis (Joanne). Alex and Diane stressed how they worked through this, Alex "touched my edges" and

“processed the fear” to come out the other side as stronger and more self-aware. Such gratifying triumph should not override the suffering of the women during this period. Alex poignantly talks about her depression, her shock at not recognising herself and the loss of the initial bonding period with her child. Diane talks of the effort to get out of bed to change her baby’s nappy and being overwhelmed by the most simple of tasks. There is little wonder that Beck (1999) described PND as a dangerous thief that causes misery and robs women of their time with their infants.

The women’s sense of self had been profoundly shaken as a result of the trauma. They equated their shock, being out of control and their actions with failure and a sense of weakness. They questioned why they could not do this properly when everyone else could. Joanne questioned whether she had done something wrong, equating her “suffering”, her “pain” with punishment (Joanne, p29). Two of the women wondered whether they could trust themselves anymore and questioned whether the birth had really been as bad as they thought. For Sandy it appeared important that the extent of her pain had been validated by both an attending registrar and later her own doctor (Sandy p4, 5). Despite the validation she questions whether she maybe has a low pain threshold and still blames herself for her failure (Sandy, p21). Joanne was unsure whether the story in her head was true, four years later she had the opportunity to see her notes which reassured her she “hadn’t over-dramatized it” (Joanne, p15).

Their lack of control during labour was a recurring theme for all women and correlates with findings in a number of studies (Allen, 1998; Beck, 2004b;; Nichol & Ayers, 2007). Coleman, 1996 (cited in Etherington, 2003) states that it is this

helplessness which makes an event subjectively overwhelming. And that those who have some element of control, no matter how small, will fare better emotionally than those who feel helpless. Indeed the described helplessness links in with one of the DSM IV criteria for PTSD, that the traumatic situation should involve fear, helplessness or horror.

Breastfeeding gave the mothers an opportunity to reassert their control, give their baby the best start in life and to prove themselves in their new role. Despite their own physical condition, which made breastfeeding painful and difficult for some, and physiological reasons which could delay lacto genesis, all mothers in this study were determined to breastfeed in order to be a “proper mum” (Sandy ,p11). Of course the stakes are high; success brings redress, fulfilment, and a closeness and pleasure in their baby. This closeness was described by Sandy as feeling like they were “still connected” (Sandy p21). This statement also suggests an element of protection and safety which perhaps she felt unable to provide during the birth trauma because she was not in control.

Unfortunately the redemptive possibility of breastfeeding was not to be experienced by all. Alex’s resultant medical condition made breast feeding excruciating, it took a while to establish and she recalls being “really screwed up about that” (Alex, 6). However her sense of achievement from eventually succeeding is shown in one of her closing comments “They are all here, they’re alive and they are gorgeous, healthy, breastfed children” (Alex p31). These findings concur with themes 1, 2, 3 and 5, 6 in Beck & Watson’s (2008) study examining the impact of birth trauma on

breastfeeding. However, they differ in that none of the women felt their body was violated by breastfeeding which was a theme in the Beck and Watson study.

Future pregnancies and births were another potentially redemptive opportunity. The desire to complete their family overrode their heartfelt fear of childbirth. All women reported an assumption that the worst had already happened and their second birth had to be better. They held on to this belief in order to override their fear. This assumption was not identified in the Thompson & Downe (2009) study which examined women's experience of a positive birth after a traumatic one. However there is concurrence in the preparation the women undertook in order to give themselves the best chance of the birth they desired. They were determined to listen to their own bodies and act on it; not be dominated by experts; to ask for help; to build relationships with appropriate staff; and in the case of Joanne to read her medical notes.

Only Sandy achieved that redemptive birth and the vindication, satisfaction and confidence that it brought and which has been noted in the Thompson & Downe, (2009) study. Sadly for Joanne and Diane, difficult second births brought their childbearing years to a premature end, as the fear and risk of future births was too large to bear. For Alex the powerful combination of her body's failure and of a world over which she had no control for a third time, was horrifying, resulting in grieving and three months of "hell" as she sank into depression (Alex, p9).

Traumatic birth had an impact on marital relationships and in this study the women focused on support or lack of it. Two women, Sandy and Diane, felt completely let down by their partners during the birth. They had silently cried for help and protection and they had felt it unforthcoming. Even whilst acknowledging that their husbands could not be expected to know what to do, the women felt terribly angry and resentful. This anger seemed to spill into the early days of motherhood when they shut their partners out, focused on their baby, and felt unable to give consideration to their partner's feelings. Other studies have also found disruption to the relationship due to lack of partner empathy (Allen, 1998; Ayers et al 2006). The other two women reported on the support from their partners in the aftermath of the trauma, which ultimately brought them closer together as a couple. Whilst a common theme in other studies has been the negative impact on couples' sex lives (Allen, 1998; Nichols and Ayers 2007) this was only mentioned by one participant who reported sex became more painful.

Previous studies have found problems in mother baby bonding (Reynolds, 1997; Ballard et al 1995; Ayers et al, 2006). This research concurred as two women spoke of initial bonding issues. Whilst this is not uncommon in the general population, the nature of the trauma seems to be the causation. Reid (2011) has noted that some mothers have difficulty separating the trauma from their baby. This appears to be the case with Joanne who attributed her initial bonding problems to her physical injuries caused by the birth (Joanne, p16). Sadly her child now experiences guilt that her birth caused her mother's condition. This has caused Joanne further regret and guilt. Alex's serious medical condition occurred after the birth and the baby was an adverse strength sapping responsibility (Alex, p5). Alex later compensated for her initial feelings with hyper-vigilant, overprotective behaviour, "*I wouldn't let her out of*

my sight" (P 19). Sandy's attachment behaviour whilst similar was all encompassing from the very start as she immediately fell in love with her baby. These attachment patterns have also been found in other studies (Allen 1998; Ayers et al. 2006; Nicholls & Ayers 2007).

Post traumatic growth was attributed to their trauma. The growth was identified in terms of increased personal strength, relating to others and new possibilities. There was a collective feeling that if "*you can get through this you can get through anything*" (Joanne, p31). The trauma and its consequences had forced them to look at, get to know and question themselves and their assumptive worlds. Diane said this process "*helped me develop as a person" (p13).* Their trauma left them wanting to and knowing they could help others. For some there was a direct correlation between their trauma and wanting to become a counsellor. Unfortunately there appears to be a paucity of research on birth trauma and PTG with which to compare findings. However a study by Souza et al (2009) found an existential element to growth in a group of Brazilian women who had suffered a near death experience in childbirth. This is in contrast to this study where no one reported a new appreciation of life or spiritual growth. There may be two reasons for this. Firstly the birth traumas were of a different nature, with one group of women aware that they had been close to death; none of the participants of this study said they thought they might die, although they were frightened. It would make sense that a near death experience would make life more precious. And perhaps Brazil is arguably a more religious society than the UK, which may explain the spiritual growth. However the timing of the Souza study is also problematic, as participants were interviewed within six weeks of their birth trauma, arguably too early to label this as PTG (Calhoun and Tedeschi, 1998) and too early to know whether this "growth" was sustainable.

The existence of PTG did not mean their trauma was forgotten, forgiven or healed. There was a duality to their experiences. Growth was not the only long term consequence. Between them, the women were also left with regret, guilt, and some fragility.

Implications for Counselling Practice

Research suggests that as many as one in three women would describe their birth experience as traumatic and as a consequence have experienced post-traumatic stress symptoms (Creedy, Shochet and Horsfall, 2000; Soet, Brack, Dilorio, 2003; Ayers, Harris, Sawyer, Farfitt and Ford, 2009). However the focus of postnatal care is with the physical rather than psychological (Peeler et al, 2013) and for a number of reasons, many women will move out of the postnatal care system without receiving any psychological help. Whilst most hospitals offer some form of postnatal service, the offering differs from hospital to hospital (Peeler et al, 2013), with most of the services (78%) being a medical debriefing rather than a psychological debriefing (Ayers, McKenzie-McHarg and Eagle, 2007). This debriefing usually involves just one session, with the mother going through her notes with medical staff in order to gain a better understanding of the birth. One might even question whether there is the potential that one session may indeed increase distress rather than decrease it (Ayers, McKenzie-McHarg and Eagle, 2007).

Given the magnitude of the problem it is probable that an individual counsellor will work with clients who have endured a traumatic birth. This research has highlighted some important challenges and implications for counselling practice. All the participants in this research had previously displayed a reluctance to talk about their

experience and their feelings. Indeed despite the elapsed time, the self-development involved in their counsellor training and personal therapy, it was the first time any participant had talked about the trauma and impact in any detail. A complex web of feelings including failure, inadequacy, disappointment, loss and a fear of making it real created a silence that was hard to break. And these feelings may also have concerned others who were most dear to the participants. Consider the difficulty in expressing the guilt, shame and sorrow surrounding bonding problems; how disloyal and frightening it might be to express feelings of anger towards and being let down by your partner; how vulnerable a woman might feel to describe giving birth, a natural process, as traumatic. Any counsellor would do well to reflect on Rogers' six necessary and sufficient conditions to therapeutic growth (1965); as regardless of the individual counsellor's therapeutic framework, surely the safety and space to explore such sensitive emotions will be dependent on the counsellor's ability to offer empathy, respect and congruence.

Given that PND and PTSD have some commonalities there is the risk that some women will be misdiagnosed with PND, the more familiar condition, when PTSD may be more appropriate (White et al, 2006). Counsellors may therefore find themselves working with misdiagnosed clients and they should be aware of this possibility. It is important that counsellors are sensitive to what Joseph and Linley (2008) call "red flag behaviours", are aware of their own level of competency and do not walk blindly into an area of suffering which might cause further harm to a client.

Chapter Six

Summary & Conclusions

The aim of this phenomenological study was to gain a rich in-depth understanding of the impact of traumatic childbirth. The research questions focused on how participants processed their experience and how it impacted on their lives.

Participants reported feelings of anger, fear, shock and being out of control during their birth. They were initially left with a sense of failure, inadequacy and weakness. The birth trauma impacted on marital relationships, the mother and baby bond and attachment behaviour. It was also a major consideration in decisions about future pregnancies; bringing childbearing to a premature end for half of the participants.

The research showed that the participants employed a number of coping mechanisms in order to protect themselves from the horror of the reality. Dissociation and repression were common features in the aftermath of the trauma. Focusing on their healthy baby allowed the mothers to stay in the present and limit rumination.

None of the women had been diagnosed with, nor tested for PTSD. However all the women stated they suffered from depression in the aftermath of the trauma. As there are commonalities in the symptoms of PTSS and depression, the possibility that some of the participants had PTSS should not be ruled out. The women worked through their depression in different ways but the importance of support was noted.

Finally PTG in terms of increased personal strength, relating to others and new possibilities were attributed to the trauma and the aftermath. However this growth exists alongside other less desirable outcomes such as regret, guilt and fragility.

Traumatic childbirth, feelings of failure, guilt, bonding issues, relationship issues, and the physical repercussions are all difficult things to admit and talk about. This is made harder by Societies rose tinted view of motherhood, and the perception that the end justifies the means. The fact that the participants had never spoken in any depth about their birth trauma, despite the considerable time lapse, is testament to this difficulty. It is evident that even today there is no standard offering of postpartum psychological care for women who have suffered a birth trauma (Peeler et al., 2013). Given the potential scale of this issue, the impact on the individual and the potential repercussions on the family and therefore society at large, it would seem sensible to devote resource to this area of research. In particular the type of support which would be beneficial. It would also seem appropriate to offer screening and monitoring of postpartum women in order to be able to offer suitable support at the appropriate time.

The research highlighted similarities and differences, light and shade, and the individual nature of the human condition. I hope that this research and the stories of my participants will be enlightening and helpful to the counselling community and medical staff at large. I hope counsellors who read this research will gain valuable insight which will broaden their understanding, sensitivity and empathy.

References

Adewuya, A. O., Ologun, Y. A., & Ibigbami, O. S. (2006) Post-traumatic stress disorder after childbirth in Nigerian women: prevalence & risk factors. *BJOG: An International Journal of Obstetrics and Gynaecology, 113,* 284-288

Agar, M.H. (1980) The right brain strikes back. In N.G. Fielding, & R.M. Lee (Eds) *Using computers in qualitative research pp181-4.* Newbury: Sage

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., and Devilly, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine, 40*, 1849-1859.

Allen, S. (1998). A qualitative analysis of the process, mediating variables and the impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, *16*, 107-131.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders.* 3rd edition. Washington, DC: American Psychiatric Association.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders.* 4th edition. Washington, DC: American Psychiatric Association.

Anderson, C., (2010) Impact of traumatic birth experience on Latina Adolescent mothers. *Issues in Mental Health Nursing, 31,* 700-707

Anderson, C. A., & Hammen, C. L. (1993) Psychosocial outcomes of children of unipolar depressed, bipolar, medically ill, and normal women: a longitudinal study. *Journal of Consulting and Clinical Psychology, 61*, 448-454.

Ayers, S. (2004) Delivery as a traumatic event: prevalence, risk factors, screening and treatment. *Clinical Obstetrics & Gynaecology, 47(3),* 552-567

Ayers, S. (2007). Thoughts and emotions during traumatic birth: A qualitative study. *Birth. 34*, 3.

Ayers, S., Eagle, A., & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine*, *11*, 389–398.

Ayers, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Posttraumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders, 119*, 200–204.

Ayers, S., McKenzie-McHarg, K., & Eagle, A. (2007) Cognitive behavioural therapy for post-traumatic stress disorder: case studies. *Journal of Psychosomatic Obstetrics & Gynaecology, 28(3),* 177-184

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth, 28,* 111–118

Ayers, S., Wright, D. B., & Wells, N. (2007). Symptoms of post-traumatic stress disorder in couples after birth: Association with the couple's relationship and parent-baby bond. *Journal of Reproductive & Infant Psychology*, *25*(1), 40-50.

BACP, (2010). *Ethical framework for good practice in Counselling and Psychotherapy.* Lutterworth: BACP.

Bailham, D., Joseph, S., (2003) Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice *Psychology, Health & Medicine*, 8, 159-168.

Ballard, C. G., Stanley A. K., Brockington I. F. (1995). Post-traumatic stress disorder after childbirth. *British Journal of Psychiatry*, *166*, 525-528.

Beck, C. T. (2004a). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*, 28–35.

Beck, C. T. (2004b). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, *53*, 216-224.

Beck, C. T. (2006). The anniversary of birth trauma: failure to rescue. *Nursing Research, 53,* 28-35.

Beck, C. T. & Watson, S. D. (2008). Impact of birth trauma on breastfeeding: A tale of two pathways. *Nursing Research, 57(4),* 228-236

Beck, C. T., & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research*, 59, (4), 241-249.

Birth Trauma Association (n.d.), retrieved January 10, 2014, from http://www.birthtraumaassociation.org.uk/

Bond, T. (2004). *Ethical guidelines for researching counselling & psychotherapy.* Rugby: BACP.

Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R.G. Tedeshci, C.L. Park, & L.G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp. 215-238). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Calhoun, L.G., & Tedeschi, R. G. (2000). Posttraumatic growth: The positive lessons of loss. In R Neimeyer (ed.) *Meaning reconstruction and the experience of loss.* Washington D.C.: American Psychological Association.

Connerty, T. J., Knott, V. (2013). Promoting positive change in the face of adversity: Experiences of cancer and post-traumatic growth. *European Journal of Cancer Care, Vol 22(3),* 334-344

Creedy, D, K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth, 27,* 104-111.

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic symptoms following childbirth. *British Journal of Clinical Psychology, 39, 35-51.*

Denis, A., Parant, O., & Callahan, S. (2011). Post-traumatic stress disorder related to birth: A prospective longitudinal study in a French population. *Journal of Reproductive and Infant Psychology, 29,* (2), 125-135.

Denscombe, M. (2010). *The good research guide (4th ed.).* Maidenhead: Open University Press.

Denzin, N. K., & Lincoln, Y. (2007). *The sage handbook of qualitative research*. London: Sage

Elliott, M. S., & Williams, D. I. (2001). Paradoxes of qualitative research. *Counselling and Psychotherapy Research, 1, (*3),181-183.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing 66(10*), 2142–2153

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2011). Separation, failure and temporary relinquishment: women's experiences of early mothering in the context of emergency hysterectomy. *Journal of Clinical Nursing, 21*, 1119–1127

Etherington, K. (2003). *Trauma, the body and transformation.* London: Jessica Kingsley Publications

Faber, N. (2006). Conducting qualitative research: A practical guide for school counsellors. *Professional School Counselling, 9(5),* 367-375.

Fones, C. (1996). Posttraumatic stress disorder occurring after painful childbirth. *Journal of Nervous and Mental Disease*, *184,*195-196.

Ford, J. D., Tennen, H., & Albert, D. (2008). A contrarian view of growth following adversity. In S. Joseph, & P. A. Linley (Eds.) Trauma, Recovery & Growth: Positive Psychological Perspectives on Posttraumatic Stress (pp.297-324). New Jersey: John Wiley & Sons.

Frankl, V. E (1984). *Man's search for meaning*. New York: Pocket Books.

Frazier, P., Tennen, H., Gavian, M., Park, C., Tomich, P., & Tashiro, T. (2009). Does self-reported posttraumatic growth reflect genuine positive change? *Psychological Science: Research, Theory & Application in Psychology and related Sciences, 20,* 912-191.

Hart, C. (2005). *Doing your masters dissertation*. London, United Kingdom: Sage

Houser, R. (2009). *Counseling and educational research: Evaluation and application*. Boston: Sage

Janoff-Bulman, R. (2004). Post-traumatic growth: three explanatory models. *The Psychological Inquiry, 15,1,* 30-34

Joseph, S. (2011). *What doesn't kill us – The new psychology of posttraumatic growth*. New York: Piatkus.

Joseph, S., & Butler, M. D. (2010). Positive changes following adversity. *PTSD Research Quarterly, 21, 3,* 1-3.

Joseph, S., & Linley, P. A. (Ed.). (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity*. Review of General Psychology, 9*, 262-280.

Joseph, S., & Linley, P. A. (Ed.). (2008). *Trauma, recovery & growth*. Hoboken: John Wiley & Sons, Inc.

Hofberg, K., & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. *British Journal of Psychiatry, 176*, 83-85

Langdridge, D. (2007). *Phenomenological psychology: theory, research & method*. Harlow, United Kingdom: Pearson Education Ltd

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Thousand Oaks, CA: Sage

Linley, P.A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17* (1), 11-21.

Lowenthal, D. (2007). *Case studies in relational research*. Basingstoke, United Kingdom: Palgrave Macmillan.

Malim, T., Birch, A., and Wadeley, A. (1992). *Perspectives in Psychology*. Hampshire, United Kingdom: Macmillan Press.

Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research.* London, United Kingdom: The Falmer Press.

McFarland, C., & Alvaro, C. (2000). The impact of motivation on temporal comparisons: Coping with traumatic events by perceiving personal growth. *Journal of Personality and Social Psychology*, *79*, 327– 343.

McGrath, J., & Linley, A. (2006). Post-traumatic growth in acquired brain injury: A preliminary small-scale study. *Brain Injury, 20,* 767–773.

McLeod, J. (1999). *Practitioner research in counselling*. London, United Kingdom: Sage.

McLeod, J. (2003). *Doing counselling research.* London, United Kingdom: Sage.

McLeod, J. (2011). *Qualitative Research in Counselling and Psychotherapy (2nd Ed.).* London, United Kingdom: Sage

McLeod, J., Elliot, R., & Wheelar, S. (2010). *Training counsellors & psychotherapists in research skills.* Lutterworth, United Kingdom: BACP.

Miliora, M. T. (1998). Trauma, dissociation, and somatization: a self-psychology perspective. *Journal of American Academy of Psychoanalysis 26,2,* 273-293

Menage, J. (1993). Posttraumatic stress disorder in women who have undergone obstetric or gynaecological procedures. *Journal of Reproduction and Infant Psychology*, *11*, 221-228.

Mintz, R. (2010). *Introduction to conducting qualitative research.* Lutterworth, United Kingdom: BACP.

Moustakas, C. (1990). *Heuristic research: Design, methodology and applications.* London, United Kingdom: Sage.

Munhall, P. L. (1988). Ethical considerations in qualitative research. *Western Journal of Nursing Research, 10*, 150-62.

Murray, L., Fiori-Cowley, A., & Hooper, R. (1996). The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcome. *Child Development, 67,* 2512 -2526

Nichols, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: A qualitative study. *British Journal of Health Psychology, 12,* 491–509

Olde E., Van der Hart, O., Kleber, R., & Van Son, M. (2006). Posttraumatic stress following childbirth: A review. *Clinical Psychology Review 26,* 1–16

Parahoo, K. (1997). *Nursing Research. Principles, Process and Issues.* London: Palgrave Macmillan

Parfitt, Y. M., & Ayers, S. (2009). The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent–baby bond. *Journal of Reproductive and Infant Psychology*, *27, 2,* 127–142

Park, C., (2010). Making sense of the meaning Literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin , American Psychological Association, 136, 2,* 257–301

Peeler, S., Stedmon, J., & Skirton, H. (2013). A review assessing the current treatment strategies for postnatal psychological morbidity with a focus on post-traumatic stress disorder. *Midwifery, 29*, 377-388

Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative Phenomenological Analysis: A discussion and critique. *Nursing Researcher, 18, (3),* 20-24

Reid, M. (2011). The impact of traumatic delivery on the mother-infant Relationship. *Infant Observation, 14*, (2), 117-128.

Rogers, C. (1965). *Client Centred Therapy*. London, United Kingdom: Constable.

Ryding, E. L., Wijma, K., & Wijma, B. (1998). Experiences of emergency caesarean section: A phenomenological study of 53 women. *Birth, 25,* 246-251.

Ryding, E. L.(1991). Psychosocial indications for caesarean section: A retrospective study of 43 cases*. ACTA Obstetricia et Gynecologica Scandinavica. 1991, 70*:47–49.

Ryding, E. L.(1993). Investigation of 33 women who demanded a caesarean section for personal reasons. *ACTA. Obstetricia et Gynecologica Scandinavica.* 72 280–285.

Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth, *Psychology & Health, 24,* (4), 457-471

Sawyer, A., Ayers, S., Young, D., Bradley, R., & Smith, H. (2012). Posttraumatic growth after childbirth: A prospective study. *Psychology and Health, 27, (3), 362–377.*

Smith, J A. (1993). The case study, in R. Bayne., & P. Nicholson (Eds.), *Counselling & Psychology for* Health *Professionals.* London, United Kingdom: Sage.

Smith, J A., Flowers, P., and Larkin, M. (2009). *Interpretive Phenomenological Analysis*. London, United Kingdom: Sage

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to methods*. London, United Kingdom: Sage

Soet, J. E., Brack, G. A., & Dilorio, C. (2003). Prevalence & predictors of women's experience of psychological trauma during childbirth. *Birth ,*30, 36-46.

Souza, P., Cecatti, J, G,. Parpinelli, M., Krupa, F., & Osis, M. (2009*).* An emerging ''maternal near-miss syndrome'': Narratives of women who almost died during pregnancy and childbirth. *Birth 36*, 2, 149-158.

Taylor, S. E., Kemeny, M. E., Reed, G. F., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *American Psychologist, 55*, 99−109.

Tedeschi, R. G. (1999) Violence transformed: Posttraumatic growth in survivors and their societies. *Aggression and Violent Behaviour: A Review Journal.*

Tedeschi, R. G., Park, C.L., & Calhoun l. G. (1998). Posttraumatic growth; conceptual issues. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: positive changes in the aftermath of crisis* (pp.1-22) Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (2004). Posttraumatic growth: conceptual foundations and empirical evidence. *Psychology Inquiry, 15*, 1-18.

Tedeschi, R. G., Calhoun, L.G., & Cann, A. (2007). Evaluating resource gain: Understanding and misunderstanding posttraumatic growth. *Applied Psychology, 56, 396–406.*

Thomson, G., & Downe, S. (2008). Widening the trauma discourse: the link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics & Gynaecology,* 29, (4). 268–273.

Thomson, G., & Downe, S. (2010). Changing the future to change the past: women's experiences of a positive birth following a traumatic birth experience. *Journal of Reproductive and Infant Psychology. 28*, 1, 102–112

Timulak, L. (2005). *Research in psychotherapy and counselling*. London, United Kingdom: Sage

University of Chester Research Governance Handbook. Version 2.3 June 2012.

United Nations Fund for Population Activities. (2003). *Maternal mortality update 2002 – A focus on emergency obstetric care.* New York: UNFPA

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology, 24, 2, 107-120*0.

Wijma, K., Soderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: A cross-Sectional study. *Journal of Anxiety Disorders, 11,* 587-597.

Wiley, L., Hollinsmartin, C., J., Marland, G., Martin, C.R., & Rankin, J. (2011). The enigma of post-natal depression: an update *Journal of Psychiatric and Mental Health Nursing*, *18,* 48–58

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method.* Maidenhead, United Kingdom: Open University Press.

Wosket, V. (1999). *The therapeutic use of self.* London, United Kingdom: Routledge

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health.* 15, 2, 215-228

Appendix 1 Research Strategy

I used four methods to retrieve relevant literature:

1. An electronic literature search. The electronic databases and search terms are recorded below:

Databases:

PsycARTICLES
Psyc-INFO
PsycBOOKS
Psychology & behavioural science collection
SocINDEX
CINAHL

Search terms:

Traumatic birth
Traumatic childbirth
Birth Trauma
Childbirth trauma
Traumatic delivery
Distressing birth
Perinatal trauma
Maternal near miss syndrome
and (impact)
and (effect)
and (relationships)

I used the Boolean operators “and” and “or” and truncation of the words trauma* and birth*.

2. A search of the university library.
3. A search of the internet using the Google search engine.
4. Further sources were located from references of papers retrieved from the other search strategies.

Appendix 2 DSM-IV-TR Criteria for Posttraumatic Stress Disorder

Appendix 3 TherapyToday.net Noticeboard Advert: Research Board Adverts

Birth Trauma: MA researcher seeking counsellors who have personal experience of a traumatic birth and would be willing to discuss its emotional impact. Semi-structured taped interview of one hour at a mutually convenient location. Contact Ann **email:**

Appendix 4 BACP Noticeboard

Noticeboard

Are you a counsellor who has personal experience of a traumatic childbirth?

Main Information

Birth Trauma: An Exploration of Mother's Experiences of the Impact of a Traumatic Birth.

I am a 3rd year MA clinical counselling student at the University of Chester and am seeking participants for my research.

I am interested in interviewing counsellors who have had personal experience of a traumatic birth and would be willing to talk about the consequential emotional impact.

Interested respondents will be provided with an information sheet and asked to complete a short questionnaire to check eligibility. The main research will be in the form of a semi-structured interview of around one hour, held at a mutually convenient place.

I have full ethical approval from the University of Chester to carry out this research.

Please contact me on email:

Thank you for your interest.

Ann Todd

Appendix 5 Research Information Sheet

Title of dissertation:
Birth Trauma: An Exploration of Mothers' Experiences of the Impact of a Traumatic Birth.

I am a third year post graduate student at Chester University studying for an MA in Clinical Counselling. Prior to this course, my career involved training, coaching and mentoring roles. I also run a small family business with my husband.

I currently volunteer as a trainee counsellor at a charity, where I work with people who bring a variety of emotional and mental health issues.

My Research

Research suggests that as many as one in three women would describe their birth experience as traumatic and have consequently experienced post-traumatic stress symptoms. Many more women do not develop symptoms but feel frightened and traumatised by the birth. Despite these figures, acknowledgement and support for their distress is usually unforthcoming. Often medical staff, family and friends are caught up in the excitement of the arrival of a baby; it is as if the ends have justified the means. As help from the NHS is far from routine, many women suffer in silence, trying to cope with feelings which are at odds with what should be a wonderful time in their life.

Birth trauma can have devastating emotional, psychological and social consequences. It can have an impact on a women's attachment to her baby; her relationship with her partner and her decision to have other children. Recent research has also shown that conversely Post Traumatic Growth is experienced by some; that out of this traumatic experience something good, some positive change can occur.

I would like to listen to your reflections on the impact a traumatic birth had on you. I would like to understand your feelings, thoughts and actions in the months and years following a birth trauma.

Why Am I Interested In This Area Of Research?

My interest in the impact of a traumatic birth stems from personal experience. Nineteen years ago, during the birth of my first child, I developed acute eclampsia. The medical care given to save our lives was exemplary. However there seemed to be no recognition that after such a traumatic sequence of events, I may have needed some emotional support too. This experience changed the course of my life.

Who Can Participate?

I would welcome participation from qualified women counsellors, who have given birth to a healthy child but who would define the birth as traumatic. At least five years should have elapsed since the birth. Due to the sensitive nature of the research, counsellors will need to feel grounded and able to discuss the experience without negative repercussions. Counsellors should have access to supervisory support and if required personal counselling. If your experience parallels these conditions, I would welcome you to participate

What Does Participating In This Research Mean?

If you meet the inclusion criteria and you would like to participate, together we will undertake an hour long audio taped interview, exploring your experience. The actual session will take longer than the hour as it would be preferable to spend 10-20 minutes discussion before the taping begins. The interview will be held at the University of Chester or I can travel to your area if Chester is not convenient. Any room used will ensure safety and confidentiality.

I will make a verbatim transcribe of the audio tape. I can guarantee accuracy of the transcript and will ensure confidentiality and anonymity. You may choose to check the transcript yourself. If you chose to do so, this may take 1 – 1.5 hours.

What Are Potential Benefits of The Research?

The potential benefit for any participant is the potential to gain a deeper awareness of how they made sense of and processed this experience. For some it may be a rare event to be able to share their experience with another. Ultimately this may have a positive and even therapeutic effect

I hope that my research will help to enlighten other counsellors and healthcare professionals and hope they will find it useful in their work. I also hope it will be useful addition to the relatively scarce research in this area.

What Are The Potential Risks?

I recognise this is an extremely personal and sensitive issue to discuss, which is why the inclusion criteria seek participants who are now grounded in their experience. However there may be a risk that revisiting this period of your life may bring up unexpected painful feelings. I would hope that you would be able to seek support from your supervisor or personal counsellor should that be necessary. I will also provide you with contact details of a number of appropriate organisations who may be able to offer help and with a contact list of BACP registered counsellors.

What Will Happen To The Results?

My dissertation will contain the results of my research, as part fulfilment of my MA in Clinical Counselling. The dissertation will be submitted to Chester University who will keep a hard copy and an electronic copy. The results may also form part of other works which are put forward for publication. Your rights to anonymity in this process are guaranteed.

Right To Withdraw

It is your right to withdraw from the process with no negative consequences. You can withdraw at any time up until the final submission of the dissertation.

Ethics

I will conduct my research in line with the BACP Code of Practice and Ethical Guidelines and the University's Research Governance Handbook. My research proposal has been subject to the vigorous scrutiny of the University's Ethics Committee and has been given approval. Whilst much thought has gone into the ethical issues during the planning stage, I am aware than ethical issues may occur at any point in the project. I will be mindful of this throughout and as I will be working with a Supervisor throughout this process, I shall seek their advice and guidance on ethical issues.

Confidentiality

Throughout the process confidentiality will be ensured. The meeting room will private and safe and the taped recording will be transferred to my password protected computer. The original recording will be deleted. You will be given a pseudonym to protect your anonymity and nothing which may identify you will be used in the research. I plan to quote appropriate parts of the interview in my dissertation but this will only be done with your permission.

Data Protection

I will adhere to the Data Protection Act 1998 and to The University of Chester Research Governance. The original taped interview will be transferred to my computer for transcription and will be deleted after the Masters Degree has been awarded. The original recording will be deleted immediately after it has been transferred to my computer. Access to my computer is password protected. All data will be kept securely when not in use. Any hard copies of the transcription, other than the final manuscript will be shredded and disposed of professionally and a certificate of destruction sought.

Complaints Procedure

Research Governance at the University of Chester ensures there is a complaints procedure in place. In the first instance contact should be made to my research supervisor. See contact details below:
Xxx

My Contact Details

Ann Todd
Email:

Appendix 6 Interview Questions

This is intended as an aide-memoire and not as a script. It is my intention to allow the interview to develop in the direction that the research participant leads whilst being mindful of the subject matter and the fact that there are questions that I would like answered

Introduction: Thank you for coming – I would like us to spend the next hour exploring your experience of the impact of the traumatic birth had on you. I have some questions, which are used as a prompt but it might be that you have other things which you would like to add and that would be great. It's important I understand what the impact was for you and not what my expectations might be.

(Ensure consent form 1+ 2 are signed)

Have you ever taken part in any research before?

Do you have any questions about the process before we start?

Questions

What were the expectations of child birth? (Prompts -Thoughts, feelings – what brought them about?)

Although this research is really looking at the impact of your traumatic birth it would be useful to briefly describe the birth and what went wrong for you. (Prompts - Can you remember your thoughts and feelings at the time? What were you feelings about yourself? How did you cope?)

Can you describe the impact on your relationships? (Prompts - With your husband/partner; with your baby; with parents or others that you are close to? Thoughts/feelings about how it impacted?)

What was the impact on your relationship with friends, particularly those who had just given birth themselves or were due to?

How did it impact on your decision to have other children (Prompts – how does that make you feel now?)

How have your thoughts/feelings changed in the time elapsed?

Did anything good come out of this trauma – post traumatic growth?

How is it for you now talking about this?

Is there anything that you would like to add – are there other areas not covered which your experience had an impact upon?

Closing: Thank you for you participation. I will now be transcribing the recording of this session so long as you are still happy for me to do that? I will then send you a copy of the transcription for you to check for accuracy. Once you have checked it I will begin my analysis and then compare it to the analysis of other data. Your anonymity will be maintained throughout.

Appendix 7 Pre Interview Questionnaire

The intention of this questionnaire is to obtain information which will allow me to determine whether a participant is suitable for this research project. There are no right or wrong answers.

Name

Address

Are you a practising counsellor at present and in supervision?

Do you have qualifications in counselling to Diploma level or above?

Do you have access to personal therapy at this time and would you be prepared to use it should the need arise?

How long ago was your birth trauma experience?

Did you give birth to a healthy child?

Do you consider yourself to be grounded in your experience and able to discuss the impact without negative repercussions?

Are you currently undergoing counselling as a repercussion of this trauma?

Are you currently pregnant or planning to be so in the near future?

Thank you for taking the time to take part in this research study.

Appendix 8 Example of Transcription with Notes and Emergent Themes

Appendix 9 Example of a Participant's Emergent Themes

Theme	Page no	line	key words
Expectations	1	8	My feeling was just put me to sleep and let me wake up with a baby
Expectations	1	14	So I had a great expectation of pain and I was very scared of that really.
Expectations	1	13	I wasn't thinking lets have a lovely birth, it was like get me in, get it over with and that's it.
fear	1	22	I started to bleed before his due date, that was traumatic, what was going on
Worry	1	29	I was worried
Dissociation/Denial?	1	30	But it was I think more that I was in a bubble than anything. I don't think it was impacting on me as I would have expected
Exhaustion	1	37	It lasted ages , like 24 hours in birth in total.
Delusional	1	5	I didn't have an epidural but I had pethidine and I was quite delusional on the pethidine
Out of control	2	13	It didn't help me stay in control very well
loss of dignity	2	14	I just remember towards the end of the birth everyone being in the room
Anger	2	17	my husband tried to take the gas and air off me and I bit his thumb because he was trying to take it off me
Baby comes first	2	20	And then baby was born. And I suppose you have got a baby then haven't you but I was in hospital for 6 days afterwards…
Distress and sadness	2	22	he doesn't know what is happening
Focus on baby	3	1	So I think straight after the birth I was more focused on baby
Depression	3	6	I was quite depressed afterwards. I did not realise that then. You kind of think perhaps this is pretty normal, you know.
Depression	3	9	It was hard to get out of bed.. I foundbaby demanding.. I had no energy.. Just focus on the baby
Physical impact	3	32	I had a lot of stitches and different things. So the physical injury meant that I was not going to go straight for another baby. Not quicl
Future childbirth plans	4	3	The depression too. I think it was a long time before I felt I could go through a birth again and that I could cope with another baby as
PTG - more assertive	4	17	They were going to send me home (during her second labour)and I said I'm not going anywhere. I am having my baby.
Pride	4	21	I was quite pleased with myself and was managing with the pain
fear	4	22	I got one big contraction and that really rocked me and it scared me. I was only 6cm, and I was frightened , is this what it is going to b
Being cared for	4	25	A lovely midwife , she was helping me, letting me walk arund. A new shift (I didn't get on with).
Not being cared for	4	31	My contractions stopped and they didn't recognise I had already been in since 12 oclock the night before (terrible story)
PTG - more assertive	4	36	She was shouting at me, … I defended myself
Anger	5	5	I was angry at her and I did argue with her
Irrational/control lost	5	8	I know I am not rational with the pethadine
Fear	5	13	The cord was around baby kneck, so that was difficult as well really. And I'm thinking is babygoing to be all right
Lack of control	5	24	the lack of control (was worse). Then the midwives I did not gel with. The first part had been so good.
Loss of redemptive birth	5	24	I was feeling safe and positive, I had got to 6cm by myself, I hadn't had to have any painlikkers and I was thinking she will be here so
PTG - support group	6	10	I had joined a support group, I had a different attitude when I went in the second time..I thanked them fro their help and took the b
Bonding	6	32	I bonded with my baby.didn't latch on very well and used to fall asleep when feeding. bUt if I talk about bonding from the point of v
Breastfeeding	7	14	Breast feeding was important. I would have been really gutted if I couldn't have breast fed. It was important to get close to my baby
PND	7	30	I think the depression was about how I got through the day and how do I get everything done, be a good wife and you know look aft
PND	8	17	I thought if anything can go wrong it will go wrong. If I had a couple of days which were good, I would think something bad is going t
Alone	9	1	The first few weeks I was in a bibble and I did not feel like going out. I did not want to go out.
cocoon of hospitalisation	9	5	when you come out of hospital your perpective has changed
Loss of self	9	12	My life will never be the same again, like I had been out of life
loss of safety net	9	16	there was a routine in hospital, it was structured. It took me along time to get that structure back in my life. A long time to think tha
difficulty with family bond	9	37	We didn't have a lovely birth, a sharing experience. It was therefore difficult getting home, you had to remodel your relationship. H
Anger with husband	10	4	I was very angry with him. I think I was abit angry with him that he wasn't more in control of the situation…It was like you know, you
Alone	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have never ever really talke
Process	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have never ever really talke
Process	10	20	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know what to expect. His p
alone	10	21	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know what to expect. His p
Process	10	32	I think you have your birth, you get over it, get on with your life, so I don't thin I did process it. That was the way my birth was, right
Alone	11	10	with friends I told them it wasn't great and I was induced
healing	11	26	I don't think I talked much after my second babies birth but I was so excited . latched on well, the breastfeeding was really enjoyabl
future pregnancy	12	3	After they talk to you about contraception - I said you can sterilise me, give him a vastectomy and give me contraception as well. I a
future pregnancy	12	17	a few years later my husband said it would be nice to have another baby and I said no thanks. ….
future pregnancy	12	20	I wouldn't put myself through that again. Its not something I would relish.
relationship with husband	12	36	there was a dramatic effect on our relationship .
Pressure on self	13	13	I wanted to be a perfect mum and do everything right, I don't know whether that was because of the birth or my personality
PTG	13	27	I suppose it developed me as a person .. More relaxed now, not such a perfectionist
future pregnancy	13	33	the most dramatic thing was foe me not wanting anymore children
loss	13	39	dignity just goes out of the window
loss of power	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby there were thing
PTG	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby there were thing
Dissociation/Denial?	14	30	I think I probably I dissociate you know because I can see myself in that situation but it is almost like I was observing what was going
Process	15	17	I just felt the symptoms and thought its part of life. It was the same with depression, it didn't occur to me that I was poorly….
PND	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I think I was very v
Process	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I think I was very v
Process	16	16	I don't think I processed it and especially the bit of anger with my husband
denial	16	16	I don't think I processed it and especially the bit of anger with my husband
relationship with husband	16	22	And I was angry with my husband
loss	16	35	you know a pat on the back , oh that's great would have been nice
needed affirmation	16	35	you know a pat on the back , oh that's great would have been nice
ptg	17	22	it certainly helped me develop as a person and to look like the second time around I was far more in control. I felt more at one with
ptg	18	25	I was like a frightened rabbit the first time, the next time I thought no I will stae what I want and need
loss	18	25	I was like a frightened rabbit the first time.
not safe	18	26	I was like a frightened rabbit the first time.
Process	19	8	I probably closed that experience off, so therefore it is hard to know what impact it had.. It is an experience that has been boxed of
didn't talk about it	19	22	I nearly passed out when my husband asked f I thought it was traumatic
alone	19	28	both of them were traumatic. But we (husband) were in different places or experienced it on a different plane.

Appendix 10 Example of a Participant's Subordinate Themes

Superordinate theme	Theme	Page no	line	key words
focus on emotions	Expectations	1	8	My feeling was just put me to sleep and let me wake up with a baby
focus on expectations	Expectations	1	8	My feeling was just put me to sleep and let me wake up with a baby
focus on emotions	Expectations	1	14	So I had a great expectation of pain and I was very scared of that really.
focus on expectations	Expectations	1	14	So I had a great expectation of pain and I was very scared of that really.
focus on expectations	Expectations	1	13	I wasn't thinking lets have a lovely birth, it was like get me in, get it over with and that's it.
focus on emotions	Fear and confusion	1	22	I started to bleed before his due date, that was traumatic, what was going on
focus on emotions	Worry	1	29	I was worried
focus on dissociation	Dissociation/Denial?	1	30	But it was I think more that I was in a bubble than anything. I don't think it was impacting on me as I would have ex
focus on process	Dissociation/Denial?	1	30	But it was I think more that I was in a bubble than anything. I don't think it was impacting on me as I would have ex
focus on emotions	Exhaustion	1	37	It lasted ages , like 24 hours in birth in total.
focus on loss	Delusional	1	5	I didn't have an epidural but I had pethidine and I was quite delusional on the pethidine
focus on loss	Out of control	2	13	It didn't help me stay in control very well
focus on loss	loss of dignity	2	14	I just remember towards the end of the birth everyone being in the room
focus on emotions	Anger	2	17	my husband tried to take the gas and air off me and I bit his thumb because he was trying to take it off me
focus on process	Baby comes first	2	20	And then baby was born. And I suppose you have got a baby then haven't you but I was in hospital for 6 days afterw
focus on relationship	Baby comes first	2	20	And then baby was born. And I suppose you have got a baby then haven't you but I was in hospital for 6 days afterw
focus on emotions	Distress and sadness	2	22	he doesn't know what is happening
focus on process	Focus on baby	3	1	So I think straight after the birth I was more focused on baby
focus on relationship	Focus on baby	3	1	So I think straight after the birth I was more focused on baby
focus on pnd	Depression	3	6	I was quite depressed afterwards. I did not realise that then. You kind of think perhaps this is pretty normal, you kr
focus on pnd	Depression	3	9	It was hard to get out of bed.. I found him demanding.. I had no energy.. Just focus on the baby
focus on physical repurcussions	Physical impact	3	32	I had a lot of stitches and different things. So the physical injury meant that I was not going to go straight for anothe
focus on physical future pregnan	Physical impact	3	32	I had a lot of stitches and different things. So the physical injury meant that I was not going to go straight for anothe
focus on physical future pregnan	Future childbirth plans	4	3	The depression too. I think it was a long time before I felt I could go through a birth again and that I could cope with
focus on PTG	PTG - more assertive	4	17	They were going to send me home (during her second labour)and I said I'm not going anywhere. I am having my ba
focus on emotions	Pride	4	21	I was quite pleased with myself and was managing with the pain
focus on emotions	fear	4	22	I got one big contraction and that really rocked me and it scared me. I was only 6cm, and I was frightened , is this wl
focus on being cared for	Being cared for	4	25	A lovely midwife , she was helping me, letting me walk arund. A new shift (I didn't get on with).
focus on being cared for	Not being cared for	4	31	My contractions stopped and they didn't recognise I had already been in since 12 oclock the night before (terrible s
focus on ptg	PTG - more assertive	4	36	She was shouting at me, ... I defended myself
focus on emotions	Anger	5	5	I was angry at her and I did argue with her
focus on loss	Irrational/control lost	5	8	I know I am not rational with the pethadine
focus on emotions	Fear	5	13	The cord was around babies kneck, so that was difficult as well really. And I'm thinking is baby going to be all right,
focus on loss	Lack of control	5	24	the lack of control (was worse). Then the midwives I did not gel with. The first part had been so good.
focus on loss	Loss of redemptive birth	5	24	I was feeling safe and positive, I had got to 6cm by myself, I hadn't had to have any painlikkers and I was thinking w
focus on ptg	PTG - support group	6	10	I had joined a support group, I had a different attitude when I went in the second time..I thanked them fro their he
focus on relationship	Bonding	6	32	I bonded with my baby but baby didn't latch on very well and used to fall asleep when feeding. bUt if I talk about b
focus on breastfeeding	Breastfeeding	7	14	Breast feeding was important. I would have been really gutted if I couldn't have breast fed. It was important to get
focus on pnd	PND	7	30	I think the depression was about how I got through the day and how do I get everything done, be a good wife and y
focus on pnd	PND	8	17	I thought if anything can go wrong it will go wrong. If I had a couple of days which were good, I would think someth
focus on loss	Alone	9	1	The first few weeks I was in a bibble and I did not feel like going out. I did not want to go out.
focus on loss	cocoon of hospitalisatior	9	5	when you come out of hospital your perpective has changed
focus on loss	Loss of self	9	12	My life will never be the same again, like I had been out of life
focus on loss	loss of safety net	9	16	there was a routine in hospital, it was structured. It took me along time to get that structure back in my life. A long
focus on relationship	difficulty with family bor	9	37	We didn't have a lovely birth, a sharing experience. It was therefore difficult getting home, you had to remodel yo
focus on relationship	Anger with husband	10	4	I was very angry with him. I think I was abit angry with him that he wasn't more in control of the situation...It was li
focus on emotions	Anger with husband	10	4	I was very angry with him. I think I was abit angry with him that he wasn't more in control of the situation...It was li
focus on loss	Alone	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have neve
focus on process	Process	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have neve
focus on process	Process	10	20	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know wha
focus on loss	alone	10	21	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know wha
focus on process	Process	10	32	I think you have your birth, you get over it, get on with your life, so I don't thin I did process it. That was the way my
focus on loss	Alone	11	10	with friends I told them it wasn't great and I was induced
focus on relationship	healing	11	26	I don't think I talked much after my second babies birth but I was so excited really latched on well, the breastfeedi
focus on future pregnancy	future pregnancy	12	3	After they talk to you about contraception - I said you can sterilise me, give him a vastectomy and give me contrace
focus on future pregnancy	future pregnancy	12	17	a few years later my husband said it would be nice to have another baby and I said no thanks. ..., I was lucky.
focus on future pregnancy	future pregnancy	12	20	I wouldn't put myself through that again. Its not something I would relish
focus on relationship	relationship with husbar	12	36	there was a dramatic effect on our relationship
focus on process	Pressure on self	13	13	I wanted to be a perfect mum and do everything right, I don't know whether that was because of the birth or my pe
focus on ptg	PTG	13	27	I suppose it developed me as a person .. More relaxed now, not such a perfectionist
focus on future pregnancy	future pregnancy	13	33	the most dramatic thing was foe me not wanting anymore children
focus on loss	loss	13	39	dignity just goes out of the window
focus on loss	loss of power	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby
focus on ptg	PTG	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby
focus on process	Dissociation/Denial?	14	30	I think I probably I dissociate you know because I can see myself in that situation but it is almost like I was observin
focus on process	Process	15	17	I just felt the symptoms and thought its part of life. It was the same with depression, it didn't occur to me that I wa
focus on pnd	PND	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I t
focus on process	Process	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I t
focus on process	Process	16	16	I don't think I processed it and especially the bit of anger with my husband
focus on process	denial	16	16	I don't think I processed it and especially the bit of anger with my husband
focu on relationship	relationship with husbar	16	22	And I was angry with my husband -
focus on loss	loss	16	35	you know a pat on the back , oh that's great would have been nice
focus on loss	needed affirmation	16	35	you know a pat on the back , oh that's great would have been nice
focus on ptg	ptg	17	22	it certainly helped me develop as a person and to look like the second time around I was far more in control. I felt r
focus on ptg	ptg	18	25	I was like a frightened rabbit the first time, the next time I thought no I will stae what I want and need
focus on loss	loss	18	25	I was like a frightened rabbit the first time.
focus on loss	not safe	18	26	I was like a frightened rabbit the first time.
focus on process	Process	19	8	I probably closed that experience off, so therefore it is hard to know what impact it had.. It is an experience that ha
focus on process	didn't talk about it	19	22	I nearly passed out when my husband asked f I thought it was traumatic
focus on aloness	frightening/alone	19	22	I pulled the drip out because of the pethadine, he went green and they asked him to leave
focus on relationship	alone	19	28	both of them were traumatic. But we (husband) were in different places or experienced it on a different plane.
focus on process	alone	19	28	both of them were traumatic. But we (husband) were in different places or experienced it on a different plane.

Appendix 11 Example of a Participant's Subordinate Themes sorted by Theme

Participant	Superordinant theme	Theme	Page no	line	key words
Participant 4	Focus on being cared for	frightening/alone	19	22	I pulled the drip out because of the pethadine, they asked him to leave
Participant 4	Focus on being cared for	Being cared for	4	25	A lovely midwife , she was helping me, letting me walk arund. A new shift (I didn't get on with).
Participant 4	Focus on being cared for	Not being cared for	4	31	My contractions stopped and they didn't recognise I had already been in since 12 oclock the night before (terrible story)
Participant 4					
Participant 4	Focus on breastfeeding	Breastfeeding	7	14	Breast feeding was important. I would have been really gutted if I couldn't have breast fed. It was important to get close
Participant 4					
Participant 4	Focus on dissociation	Dissociation/Denial?	1	30	But it was I think more that I was in a bubble than anything. I don't think it was impacting on me as I would have expecte
Participant 4					
Participant 4	Focus on emotions	Anticipated fear	1	8	My feeling was just put me to sleep and let me wake up with a baby
Participant 4	Focus on emotions	anticipated pain	1	14	So I had a great expectation of pain and I was very scared of that really.
Participant 4	Focus on emotions	Fear and confusion	1	22	I started to bleed before due date, that was traumatic, what was going on
Participant 4	Focus on emotions	Worry	1	29	I was worried
Participant 4	Focus on emotions	Exhaustion	1	37	It lasted ages , like 24 hours in birth in total.
Participant 4	Focus on emotions	Anger	2	17	my husband tried to take the gas and air off me and I bit his thumb because he was trying to take it off me
Participant 4	Focus on emotions	Distress and sadness	2	22	he doesn't know what is happening
Participant 4	Focus on emotions	Pride	4	21	I was quite pleased with myself and was managing with the pain
Participant 4	Focus on emotions	fear	4	22	I got one big contraction and that really rocked me and it scared me. I was only 6cm, and I was frightened , is this what it i
Participant 4	Focus on emotions	Anger	5	5	I was angry at her and I did argue with her
Participant 4	Focus on emotions	Fear	5	13	The cord was around baby kneck, so that was difficult as well really. And I'm thinking is baby going to be all right
Participant 4	Focus on emotions	Anger with husband	10	4	I was very angry with him.
Participant 4					
Participant 4	Focus on expectations	Anticipated fear	1	8	My feeling was just put me to sleep and let me wake up with a baby
Participant 4	Focus on expectations	anticipated pain	1	14	So I had a great expectation of pain and I was very scared of that really.
Participant 4	Focus on expectations	Expectations	1	13	I wasn't thinking lets have a lovely birth, it was like get me in, get it over with and that's it.
Participant 4					
Participant 4	Focus on future pregnancy	future pregnancy	12	3	After they talk to you about contraception - I said you can sterilise me, give him a vastectomy and give me contraception
Participant 4	Focus on future pregnancy	future pregnancy	12	17	a few years later my husband said it would be nice to have another baby and I said no thanks, I was lucky.
Participant 4	Focus on future pregnancy	future pregnancy	12	20	I wouldn't put myself through that again. Its not something I would relish
Participant 4	Focus on future pregnancy	future pregnancy	13	33	the most dramatic thing was foe me not wanting anymore children
Participant 4	Focus on future pregnancy	Physical impact	3	32	I had a lot of stitches and different things. So the physical injury meant that I was not going to go straight for another bab
Participant 4	Focus on future pregnancy	Future childbirth plans	4	3	The depression too. I think it was a long time before I felt I could go through a birth again and that I could cope with anot
Participant 4					
Participant 4	Focus on physical impact	Physical impact	3	32	I had a lot of stitches and different things. So the physical injury meant that I was not going to go straight for another bab
Participant 4					
Participant 4	Focus on loss	Delusional	2	5	I didn't have an epidural but I had pethidine and I was quite delusional on the pethidine
Participant 4	Focus on loss	Out of control	2	13	It didn't help me stay in control very well
Participant 4	Focus on loss	loss of dignity	2	14	I just remember towards the end of the birth everyone being in the room
Participant 4	Focus on loss	Irrational/control lost	5	8	I know I am not rational with the pethadine
Participant 4	Focus on loss	Lack of control	5	24	the lack of control (was worse). Then the midwives I did not gel with. The first part had been so good.
Participant 4	Focus on loss	Loss of redemptive birth	5	24	I was feeling safe and positive, I had got to 6cm by myself, I hadn't had to have any painlikkers and I was thinking she wil
Participant 4	Focus on loss	Alone	9	1	The first few weeks I was in a bibble and I did not feel like going out. I did not want to go out.
Participant 4	Focus on loss	cocoon of hospitalisation	9	5	when you come out of hospital your perpective has changed
Participant 4	Focus on loss	Loss of self	9	12	My life will never be the same again, like I had been out of life
Participant 4	Focus on loss	loss of safety net	9	16	there was a routine in hospital, it was structured. It took me along time to get that structure back in my life. A long time t
Participant 4	Focus on loss	Alone	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have never ever
Participant 4	Focus on loss	alone	10	21	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know what to e
Participant 4	Focus on loss	Alone	11	10	with friends I told them it wasn't great and I was induced
Participant 4	Focus on loss	loss	13	39	dignity just goes out of the window
Participant 4	Focus on loss	loss of power	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby there
Participant 4	Focus on loss	loss	16	35	you know a pat on the back , oh that's great would have been nice
Participant 4	Focus on loss	needed affirmation	16	35	you know a pat on the back , oh that's great would have been nice
Participant 4	Focus on loss	loss	18	25	I was like a frightened rabbit the first time.
Participant 4	Focus on loss	not safe	18	26	I was like a frightened rabbit the first time.
Participant 4					
Participant 4	Focus on PND	Depression	3	6	I was quite depressed afterwards. I did not realise that then. You kind of think perhaps this is pretty normal, you know.
Participant 4	Focus on PND	Depression	3	9	It was hard to get out of bed.. I found baby demanding.. I had no energy.. Just focus on the baby
Participant 4	Focus on PND	PND	7	30	I think the depression was about how I got through the day and how do I get everything done, be a good wife and you kn
Participant 4	Focus on PND	PND	8	17	I thought if anything can go wrong it will go wrong. If I had a couple of days which were good, I would think something ba
Participant 4	Focus on PND	PND	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I think I
Participant 4					
Participant 4	Focus on Process	Dissociation/Denial?	1	30	But it was I think more that I was in a bubble than anything. I don't think it was impacting on me as I would have expecte
Participant 4	Focus on Process	Baby comes first	2	20	And then baby was born. And I suppose you have got a baby then haven't you but I was in hospital for 6 days afterwards..
Participant 4	Focus on Process	Focus on baby	3	1	So I think straight after the birth I was more focused on baby
Participant 4	Focus on Process	Process	10	16	I was one of those people who go through stuff, you pick yourself up, you get on with life, I don't think I have never ever
Participant 4	Focus on Process	Process	10	20	when I talked to my husband about doing this, he asked if mine was a traumatic birth. Because you don't know what to e
Participant 4	Focus on Process	Process	10	32	I think you have your birth, you get over it, get on with your life, so I don't thin I did process it. That was the way my birth
Participant 4	Focus on Process	Pressure on self	13	13	I wanted to be a perfect mum and do everything right, I don't know whether that was because of the birth or my persona
Participant 4	Focus on Process	Dissociation/Denial?	14	30	I think I probably I dissociate you know because I can see myself in that situation but it is almost like I was observing wha
Participant 4	Focus on Process	Process	15	17	I just felt the symptoms and thought its part of life. It was the same with depression, it didn't occur to me that I was poor
Participant 4	Focus on Process	Process	15	27	I never considered it was depression. I was going to a support group and I would tell them if I had a horrible day . I think I
Participant 4	Focus on Process	Process	16	16	I don't think I processed it and especially the bit of anger with my husband
Participant 4	Focus on Process	denial	16	16	I don't think I processed it and especially the bit of anger with my husband
Participant 4	Focus on Process	Process	19	8	I probably closed that experience off, so therefore it is hard to know what impact it had.. It is an experience that has bee
Participant 4	Focus on Process	didn't talk about it	19	22	I nearly passed out when my husband asked f I thought it was traumatic
Participant 4	Focus on Process	alone	19	28	both of them were traumatic. But we (husband) were in different places or experienced it on a different plane.
Participant 4					
Participant 4	Focus on PTG	PTG - more assertive	4	17	They were going to send me home (during her second labour)and I said I'm not going anywhere. I am having my baby.
Participant 4	Focus on PTG	PTG - more assertive	4	36	She was shouting at me, … I defended myself
Participant 4	Focus on PTG	PTG - support group	6	10	I had joined a support group, I had a different attitude when I went in the second time..I thanked them fro their help and
Participant 4	Focus on PTG	PTG	13	27	I suppose it developed me as a person .. More relaxed now, not such a perfectionist
Participant 4	Focus on PTG	PTG	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that. With the second baby there
Participant 4	Focus on PTG	ptg	17	22	it certainly helped me develop as a person and to look like the second time around I was far more in control. I felt more a
Participant 4	Focus on PTG	ptg	18	25	I was like a frightened rabbit the first time, the next time I thought no I will stae what I want and need
Participant 4					
Participant 4	Focus on relationships	Baby comes first	2	20	And then babywas born. And I suppose you have got a baby then haven't you but I was in hospital for 6 days afterwards…
Participant 4	Focus on relationships	relationship with husband	16	22	And I was angry with my husband
Participant 4	Focus on relationships	Focus on baby	3	1	So I think straight after the birth I was more focused on baby
Participant 4	Focus on relationships	Bonding	6	32	I bonded with my baby but didn't latch on very well and used to fall asleep when feeding. bUt if I talk about bonding fro
Participant 4	Focus on relationships	difficulty with family bond	9	37	We didn't have a lovely birth, a sharing experience. It was therefore difficult getting home, you had to remodel your rel
Participant 4	Focus on relationships	Anger with husband	10	4	I was very angry with him. I think I was abit angry with him that he wasn't more in control of the situation…It was like yo
Participant 4	Focus on relationships	healing	11	26	I don't think I talked much after my second babies birth but I was so excited really latched on well, the breastfeeding wa
Participant 4	Focus on relationships	relationship with husband	12	36	there was a dramatic effect on our relationship
Participant 4	Focus on relationships	alone	19	28	both of them were traumatic. But we (husband) were in different places or experienced it on a different plane.

Appendix 12 Example of Creation of Master Themes

All themes were collated on one spreadsheet and sorted by theme and colour coded by participant. Below is only a snap shot of a small part of the table. Theme names were then standardised. These then fell into the clusters as shown in the main text. At this stage some themes had to be discarded.

Part3	Focus on emotions	shock	1	19	It literally took my breath away, I was getting no respit
Part3	Focus on emotions	Out of cor	2	4	I was getting agitated and irritated and getting very tir
Part3	Focus on emotions	Out of cor	2	10	So this rollercoaster of wow what is ging on here. I did
Part3	focus on emotions	shock of p	2	31	Then the anaestic wore off and I hit theroof. The pain I
Part3	Focus on emotions	shock of p	3	35	the pain from the episiotomy makes my labour seem l
Part3	focus on emotions	humiliatic	4	30	You feel like a piece of meat... I just wanted all to stop,
Part3	Focus on emotions	emotions	5	10	It shared me to death
Part3	focus on emotions	fear	7	35	she knew the fear I had that if this went on and I had a
Part3	Focus on emotions	second pr	8	33	As I entered the hospital to have my econd child I was
Part3	Focus on emotions	fear	12	26	it is the fear that nobody is listening to you, that was m
Part3	Focus on emotions	Nobody ca	13	1	It was as if I didn't matter. And that was scary. It was th
Part3	Focus on emotions	fear	14	1	My first labour is the most scariest thing I have ever do
Participan	Focus on emotions	Anticipate	1	8	My feeling was just put me to sleep and let me wake u
Participan	Focus on emotions	anticipate	1	14	So I had a great expectation of pain and I was very scar
Participan	Focus on emotions	Fear and c	1	22	I started to bleed before his due date, that was trauma
Participan	Focus on emotions	Worry	1	29	I was worried
Participan	Focus on emotions	Exhaustio	1	37	It lasted ages , like 24 hours in birth in total.
Participan	Focus on emotions	Anger	2	17	my husband tried to take the gas and air off me and I b
Participan	Focus on emotions	Distress a	2	22	he doesn't know what is happening
Participan	Focus on emotions	Pride	4	21	I was quite pleased with myself and was managing wit
Participan	Focus on emotions	fear	4	22	I got one big contraction and that really rocked me and
Participan	Focus on emotions	Anger	5	5	I was angry at her and I did argue with her
Participan	Focus on emotions	Fear	5	13	The cord was around her kneck, so that was difficult as
Participan	Focus on emotions	Anger wit	10	4	I was very angry with him. He tried to take my gas and
Participan	Focus on expectations	Anticipate	1	8	My feeling was just put me to sleep and let me wake u
Participan	Focus on expectations	anticipate	1	14	So I had a great expectation of pain and I was very scar
Participan	Focus on expectations	Expectatic	1	13	I wasn't thinking lets have a lovely birth, it was like get
part1	Focus on expectations of birth	Expectatic	1	15	I was concerned
part1	Focus on expectations of birth	Expectatic	1	27	so there was something going on - anxiety
part1	Focus on expectations of birth	Expectatic	2	6	hoped .. Perfect child, perfect preganancy and perfect
part1	Focus on expectations of birth	Expectatic	2	14	I was terrified of catastrophes
Part3	Focus on expectations of birth	Expectatic	1	11	You are scared.. You are worried because of the horror
Part3	Focus on future preganancies	2nd pregn	6	5	I was scared it was going to happen again
Part3	Focus on future preganancies	Redempti	6	13	She was a darling, she was 7 pounds wet through, I oul
Part3	Focus on future preganancies	desire for	7	12	I was determined to have another baby. I think I was in
Part3	Focus on future preganancies	second pr	7	20	it is not until you remember last time that it all comes
Part3	Focus on future preganancies	assumptiv	7	26	I had reconciled myself to the fact that it couldn't be ar
Part3	Focus on future preganancies	fear	7	35	she knew the fear I had that if this went on and I had a
Part3	Focus on future preganancies	second pr	8	26	sometimes I would think ooh I am pregnant and the fir
Part3	Focus on future preganancies	second pr	8	33	As I entered the hospital to have my econd child I was
Part3	Focus on future preganancies	Redempti	9	4	My daughter arrived, what an easy birth - we call her o
Part3	Focus on future preganancies	Redempti	9	13	I went on to have another preganancy.. I think probabl
Part3	Focus on future preganancies	Redempti	9	33	Yeehar - I can do this, yes!
Part3	Focus on future preganancies	impact on	10	33	I had no problems but I had been promised a caesarian
Part3	Focus on future preganancies	impact of	10	18	I was quite calm about it because I knew by then that t
Part3	Focus on future preganancies	Redempti	10	36	It was so easy, thank God
Participan	Focus on future pregnancy	future pre	12	3	After they talk to you about contraception - I said you
Participan	Focus on future pregnancy	future pre	12	17	a few years later my husband said it would be nice to h
Participan	Focus on future pregnancy	future pre	12	20	I wouldn't put myself through that again. Its not somet
Participan	Focus on future pregnancy	future pre	13	33	the most dramatic thing was foe me not wanting anym
Participan	Focus on future pregnancy	Physical ir	3	32	I had a lot of stitches and different things. So the physi
Participan	Focus on future pregnancy	Future chi	4	3	The depression too. I think it was a long time before I f
part1	Focus on Loss	lostin her	28	3	I was lost in myself and I didn't communicate well
part1	Focus on Loss	Self doub	5	11	I stared at this child and thought Oh my God I can't mar
part1	Focus on Loss	breastfee	6	22	I had gone through this trauma .. But I had a baby to lo
part1	Focus on Loss	shock of r	6	30	Two days before delivery I had been happy, then two v
part1	Focus on Loss	Grieving f	10	6	I felt really angy, absolutely pissed off, flt like hell, gri

Appendix 13 Example of a Theme with Participants Key Words or Quotes

Particip	Superord	Emergent Theme			
part1	Focus on PTG	finding strength in self	25	12	worked it out by myself by digging deep. I'm miserable but you know what im ok, im still he
part1	Focus on PTG	PTG/relationship with husband	28	10	we didn't speak much but he was there for me. I recognised how strong he was and as I reco
part1	Focus on PTG	PTG	30	20	the growth involved knowing where my edges were…..
part1	Focus on PTG	ptg	31	8	more compassionate, more vulnerable, its made me nicer, softer
part1	Focus on PTG	ptg in relationship	32	10	we have seen each other naked in so many ways metaphorically, emotionally and that was a
part1	Focus on PTG	PTG	27	36	there were lots of stresses in our relationship but ultimately it brought us closer together. \
NB part 2 I think a lot of the honouring female stuff is more about self??? Move it!					
part2	Focus on PTG	PTG	22	7	it has made me who I am
part2	Focus on PTG	Strength through suffering	22	8	it has made me stronger… hysterectomy a piece of cake in comparison
part2	Focus on PTG	PTG	23	8	healing it
part2	Focus on PTG	Healing of self	23	15	honour part of my womanhood that has been denied
part2	Focus on PTG	PTG	23	14	phychological reprogramming
part2	Focus on PTG	Regaining power	23	26	honouring feminine power
part2	Focus on PTG	PTG	24	30	living in the now
part2	Focus on PTG	Existentialism	24	31	only way to survive
part2	Focus on PTG	living for the now	25	1	it got lost
part2	Focus on PTG	PTG	25	20	we were more prepared
part2	Focus on PTG	ptg - counselling	26	11	counselling .. Brought everything together
part2	Focus on PTG	ptg - affinity with other women	26	27	empathise with other women particularly
part2	Focus on PTG	ptg - bond with other women	27	2	energy ...specifically work with women
part2	Focus on PTG	redemption - forgive self	28	na	
part2	Focus on PTG	ptg-strength	31	7	you can get through this you can get through anything. Belief in self
part 3	Focus on PTG	ptg	15	25	I would not be a martyr to it again. I would scream blue murder. I would be demanding etc
part 3	Focus on PTG	PTG	17	27	it gave me the stregth to go onto later labours knowing that I wouldn't leave myself in their
part 3	Focus on PTG	ptg	19	7	ooh god that is me , and if I can help I will talk my heart out
part 3	Focus on PTG	knowledge gave her power	8	12	the quick contractions, this time I understood this is how my body gives birth
part 4	Focus on PTG	PTG - more assertive	4	17	They were going to send me home (during her second labour)and I said I'm not going anywh
part 4	Focus on PTG	PTG - more assertive	4	36	She was shouting at me, … I defended myself
part 4	Focus on PTG	PTG - support group	6	10	I had joined a support group, I had a different attitude when I went in the second time..I tha
part 4	Focus on PTG	PTG	13	27	I suppose it developed me as a person .. More relaxed now, not such a perfectionist
part 4	Focus on PTG	PTG	14	6	I felt very very out of control. They were in control and I couldnt say I would like this or that.
part 4	Focus on PTG	ptg	17	22	it certainly helped me develop as a person and to look like the second time around I was far
part 4	Focus on PTG	ptg	18	25	I was like a frightened rabbit the first time, the next time I thought no I will stae what I want

Appendix 14 Journal

The ethical issues for the dissertation are quite sensitive, much consideration is needed. It feels quite a responsibility and yet I think this is an important area which by the looks of it is under-researched. I've looked at some of the other more sensitive topics and I think this one should be possible if handled with care. The last thing I want to do is traumatise somebody. The responsibility seems huge.
The proposal has taken an age. The terminology is a foreign language. Have to read and reread to try and make sense. Picked IPA – like the idea of looking at one participant at a time and feels that there has to be an element of interpretation anyway – particularly given my background - so why not be upfront.
So proposal passed and onto ethics application. Have looked at a number of other studies and have tried to think of all the possible ways I can minimise risk. Quite enjoyed this part – probably because it seems far more practical than philosophical.
I handed my proposal in and there is a glut which the ethics committee are working through. So looks like it could take some time. Strange feeling of wanting to get on with things – but effort would be wasted if it doesn't get through.
Ethics Approval granted – and after all that worry everything is fine. I need to revise the title to show that the birth trauma is in relation to the mother. I'm now behind with my initial timetable and quite nervous because this has to fit into my work and home life.
How can trying to come up with a title take so long? Everyone I write looks clumsy.
Want to feel really prepared so am trying to do the methodology and lit review before I start looking for participants. Lit is really interesting but confusing – they seem to use different methods to measure PTSD – so not sure whether it is PTSD or sub ptsd. Have started to make a spread sheet of the studies to try to classify but actually really quite difficult to assess. I don't know if it matters too much unless you are trying to compare the results of studies. Thinking that if PTSD is a continuum and I am looking at the individual, I shouldn't get drawn into the pathology of it. Individual people, individual reactions.
It's a lot of reading for what is in effect quite a short chapter of the dissertation. Now have a chapter which is three times the length it should be. I should stop the reading now and believe that I really have enough but I keep looking just in case there is that one gem. Not sure how much trauma theory to put in – lots of competing views – but how do I talk about these in such a short chapter? Should I be concentrating on the research into birth trauma?
Can't find anything specific on PTG and birth trauma – have searched and searched. One study which mentions it in a whole description of other things. Really surprised – up and coming area for research. Worried I've missed it somewhere.
Decided I should have a counselling session myself to look at my own birth trauma. I feel much grounded in it but ethically I needed to make sure. It was a lovely session.

Had decided to do a trial interview with a counsellor I know who had a birth trauma. The role of interviewer/researcher now seems quite alien – it is very hard to switch off being a counsellor. The questions felt really intrusive. I'm glad I did the trial because I realised I didn't follow up on the questions enough – I need more "could you tell me more about that "questioning. Also I think maybe I need more of a prompt sheet, than just a question sheet. We did cover everything in about 55 minutes so that was reassuring.
Started sending my advert out today. Have phoned a number of agencies in the northwest. Actually everyone has been really helpful – thank goodness. I've emailed my advert and put some in the post as a backup to all. It's quite time consuming and very nerve wracking.
Put the advert in therapy today and BACP noticeboards – it was quite easy.
Interesting ethical dilemma today from a respondent. Have had to be really careful with this but thank goodness I thought about it first. It really alerted me to how you have to be so careful with absolutely everything you do and say – think of all implications. I can't even write the issue in here because it is too specific and there might be a confidentiality issue – when in doubt leave it out!
Another respondent - really keen to tell their story. Spoke to her on the phone and went through the eligibility criteria. And she is eligible. I've sent her background information to the study and the questions showing the areas I will ask about, although I've made it clear that she may want to talk about other things I've not thought about – and that is good. If she is happy with this we will go ahead.
First interview today. I felt quite nervous and so I made a check list of all the things I needed to take and the things I need to do. The participant was very open, this is something she has obviously given a great deal of thought to over the years. One of my final questions was how had they found the process and she said it had been very helpful and therapeutic in a way – although she realised that hadn't been the remit.
This is such a responsibility. My participant's story was so detailed. In a way I wish I could put all of it in the study, as it was so beautifully said – but I my information sheet stated that I would only use parts of the transcript. I need to make sure I don't lose the essence of her story when I dissect it and put it back together again. This process is incredibly moving. I will need to make sure I take care of myself
The analysing takes much longer than I thought it would. I've listened to the tape with my transcript a few times and then I have read and reread the transcript on its own. I've made copious notes in the columns and I've tried to do this in a number of ways – writing down the first thing that comes into my head, highlighting words and sentences which have a meaning, and one method I found really interesting was reading the transcript backwards. I tried this section by section and sentence by sentence. It did throw up some things that I had missed previously. So I'm going to use this for all transcripts. I've also colour coded the themes as suggested by Smith – highlighting them. I needed to do it on hard copy for this part of the analysis but I'll do the rest on the PC. It takes such a long time. Each time I read it takes well over an hour. Sometimes I have felt that I can't think of anything else. I'm going to leave this

for a couple of days – perhaps it will become clearer with a break.
I was checking birth trauma websites and there is a new study which has been announced by a leading researcher in the field– and it is looking at PTG after birth trauma. The timing seems ironic. I've been in touch with her and we have swopped a number of emails. She has been really helpful – sending me her research papers – I actually already had all bar one, which was on breastfeeding and will be really useful. She has also pointed me to a new blog which I didn't know existed. This is by another leading researcher and it's brand new. Thrilled that I can be so up-to-date with the research in this area.
Did some research on line. The women's birth accounts on TABs are very detailed and extremely distressing. I found myself getting quite upset, can certainly see how vicarious traumatisation can take hold. I'm glad I don't need to keep reading more and more of these – far more detail in the written accounts than in participant 1 account – although of course this study is on the impact.
Still thinking about the TABs accounts so will take to supervision today.
Managed to complete the analysis on participant 1. I moved from the hard copy of the transcript to listing the subordinate on a spread sheet. I then added in columns for the participant, the page number, line number and either the appropriate quote or key words. I think I may have gone overboard on themes and superordinate themes! It made the eventual sort quite difficult. I think I need to be circumspect with my superordinate themes and make a more informed decision on them at the time – think about them more at the time, than thinking I can reduce them to the extent I had to with this participant.
Good session with my study buddy today. Looked at our methodology sections and compared our knowledge from books we'd read and information from our supervisors. Really useful for us both I think.
Analysis on the second participant has been challenging in a different way. Her story is quite similar to mine in many ways and I found myself drifting off into my story. I felt it was getting in the way. It hasn't been upsetting – just in the way. I've decided to tape my story, so that I can be said and I don't need to have to keep thinking about it.
I am finding IPA quite challenging. Whilst it feels more comfortable to analyse one participant at a time, to immerse in their lived experience. It is also challenging when you have analysed a couple of participants because it seems really natural for your mind to start comparing them, to get excited about common themes. I need to keep a note here so that I can come back to it when I'm doing the analysis and let go of it now and concentrate on each participant one at a time.. Part1 story – working through trauma – knows herself so much better at the end - re-engagement very powerful. Similar process to part 2s depression?
Have been working with a client for a couple of months. It has been a privilege throughout but today she worked on something that either I have missed before or it was too deep for her to mention. It relates to her birth experience and so fundamental and a huge break through. I feel emotional thinking about it. Would I have been so open to what she was saying without this research? I don't think I would have been. Thoroughly honoured to have been allowed in.
I now have all my participants, in fact I have more than I need and have had to stop recruiting. This is surprising – it was such a slow start at first. I've actually found this process quite nerve wracking. A couple of people didn't meet the eligibility criteria – and as I'd explained that in my preamble that felt okay. However because I had the poster at a lot of agencies, I did receive a few calls after I had all my participants. I did feel terrible having to explain that. This is such a sensitive topic and for women to

call me, they would probably have to think long and hard. And so then to be told that the study is full, felt uncomfortable for me. I have been in touch with the organisations I sent advert to and asked them to take the advert down. It's interesting that all my participants had their birth trauma 15+ years ago. I have only had one person reply whose trauma is only 5 years ago. Unfortunately she didn't meet the inclusion criteria. Participants have been chosen on a first come basis – as long as they meet the eligibility criteria. I didn't want to bias what I found by being selective.
Have just completed the analysis of my third participants tape. Her story is so moving The love for her baby is beautiful. The responsibility for this is weighing heavy. I hope I can do these brave women justice.
The literature review is now in a good draft form. I've found it so difficult to keep it in the word count.
I have completed the final analysis which has been extremely time consuming and probably less clear cut than I thought it would be. I found that I had not always classified themes and subordinate themes in common language between participants. I had to question why I had categorised themes in a particular way. There was a considerable amount of returning to the transcripts to check and recheck understanding. Some sub themes could fall into two master themes. This made me question whether various themes were in fact sub themes that should form a cluster together. In doing the final analysis between the participants I have found putting the quotes on the spread sheet to be useful and timesaving in what is a long drawn out process. I have spent a lot of time reflected on the findings and returning to the original transcripts to check my understanding and analysis. It is interesting that time and space allows different perspectives to arise and a questioning of my own previous assumptions. One area I hadn't brought into the findings but on looking again I could see a link between all participants. How had I missed it – because it wasn't important to me?
Another session with my study buddy to look at each other's findings. We are using different methodology, so it has been quite interesting. Looking at her coloured cards and her process seemed quite complicated. Perhaps it shows that I have learnt quite a lot about IPA and feel more comfortable with it than I thought. It was a useful exercise today – good to sense check and have to justify why I had come up with certain themes.
I have completed the draft of findings and am concerned as to whether I really am showing the reader the essence of the participant's experience. Have I chosen the right quotes? Have I given each participant equal voice? Have I remembered to use the notes that I made all over the transcripts. How difficult it is include all that you would want. Once again I am surprised by how little can be written in each chapter. I'm not as comfortable with this as I thought I might be. I have a responsibility to my participants; I do not want to let them down at this stage. I am going to leave this chapter for a few days in order to give some clarity.
It was my daughter's birthday today and I was trying to complete the findings chapter. I found it distracting. It was hard to put it out of my mind when I was writing about similar experiences. I have never had anniversary problems with her birth before and I don't think I had today but as I wrote I was drifting into memories of my experience. I was concerned that it might affect the findings, so I will leave this chapter for today.

Both the findings and discussion have been completed in draft form. This is a huge weight off my mind. It has taken so much longer than I thought was possible. I have gone back to my literature review and am going to add/subtract in line with my findings. Could I be nearly there?
So it is finished. I wish I had more time. I wish I had a larger word count. I wish there had been to allow a follow up. As I was writing the findings, I became aware of more questions I wanted to ask. My hope is that I have done justice to the brave women who shared their story and that in dividing their story into parts I have not lost the essence of their experience.

Appendix 15 Copy of Ethical Application

1. Summary of the ethics issues

Please summarise what you think are the ethical issues in this study. The questions that follow will give you an opportunity to demonstrate how you will manage these issues in the conduct of your research.

I intend to carry out my research in line with the BACP Code of Practice and Ethical Guideline (Bond 2004) and the University of Chester Research Governance (2012). I am acutely aware of the sensitivity of this research and the ethical principle of nonmaleficence is uppermost in my mind. Hart (2005) points out that ethical issues have to be considered throughout all stages of research, from design to reporting and I plan to use this knowledge as a check list. I am aware that despite the best planning, in qualitative research the unexpected may occur. I therefore intend to seek the guidance and the support from my supervisor where necessary.

The ethical concern uppermost in my mind with this piece of research is the potential for harm to my participants. I will be exploring sensitive and painful areas. Whilst I will ensure that interviews are handled with the utmost sensitivity and hold the participants well-being as paramount, I have to acknowledge that there is a risk that such exploration may possibly re-traumatise a participant. I hope to show in the sections below how I aim to minimise any such risk.

There is also a potential risk to my own mental health. Whilst I feel grounded in my own traumatic birth experience, it would be naïve to assume there is no risk. Again I will discuss how I will manage this below.

Given the sensitive and intimate nature of this research informed consent and process consent is paramount. It is important that participants are fully aware of what this research entails, the implications of taking part in this research, and have had time to consider what it will feel like to have their experience out in a general domain. Furthermore a semi-structured interview has the potential to tap into a sensitive area which a participant had not been prepared for and which they would not want included in the study. It will be important that participants have the knowledge that they are free to or veto certain areas discussed and to withdraw at any time without negative repercussions.

Anonymity and confidentiality are further ethical issues. The safeguarding of these is discussed at length in later sections. However I will need to advise participants that there are limits to confidentiality in the case of risk of harm to others or breaking the law (for example the Terrorism Act (2000); the Drug Trafficking Act (1986)).

In choosing IPA as my method of data analysis, I have accepted that whilst I will strenuously try to “bracket” (Husserl 1960) my own pre-conceptions and assumptions, any analysis I produce will still be an interpretation of the participant’s experience. I am aware that recent researchers have IPA to a different level of interpretation which critically interrogates the participants’ account and takes the researcher beyond the participants own words and understanding. As Willig points out (2008) this has ethical implications re the imposition of meaning and giving or denying of voice to the participants. I shall seek continuous clarification from my supervisor to ensure I that my work does not fall into this category.

2a. What is the potential for discomfort, distress, inconvenience or changes to the lifestyle of research participants?

In exploring the impact of traumatic birth, experiences which were painful and distressing will be discussed. The last thing I would want to do is to instigate any further hurt or traumatisation. That is why I am putting in place safeguards to ensure that participants chosen are already robust and grounded in their experience.

I will also ensure that I conduct the interview in a sensitive manner, whilst being mindful that this is research and not a counselling session. Nevertheless I am sure that all that I have learnt in the last three years will be beneficial to my interviewing technique in this sensitive area. My own inner knowing and natural empathy of a traumatic birth should enhance the sensitivity required and may make participants more comfortable.

I have stipulated that chosen participants must be counsellors who are having on-going supervision. This will enable the participants to have on-going support should any unforeseen issues emerge. Chosen participants should also be willing to have counselling should the need arise. I will provide Information of BACP accredited counsellors and a number of appropriate organisations who may be able to offer help.

2b. Are there any particular requirements or abstentions that will be imposed upon the participant (for example, multiple attendance sessions or visits, abstention from alcohol, tobacco and so on)?

N/A

2c. What is the potential for benefit for research participants?

I believe this study has the potential to meet the ethical principle of beneficence, as recollection may have positive and even therapeutic effects for the participants (Smith, 1993; Rennie, 1994; Beck, 2004).

Additionally the final research question will ask whether post traumatic growth occurred. There is the possibility that it has not been given the significance or weight which might have been attributed to the more difficult aspects of the impact of traumatic birth. A greater awareness could be beneficial.

2d. What is the potential for adverse risks, hazards, pain, discomfort, distress or inconvenience for researchers themselves? (Please note that "negligible" is defined as not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests).

I have experienced a traumatic birth myself and I am aware that in researching this area in detail, there is a potential risk to my own psychological wellbeing. I have taken the same precautions for my own wellbeing as I have stipulated for my participants. In the last three years I have already undertaken a considerable amount of personal development and counselling; additionally my traumatic birth experience was 18 years ago, long enough ago for me to feel at peace with the experience.

However as a precautionary measure I have engaged the assistance of a personal counsellor. I also have the support of two counselling supervisors and my academic tutor. I aim to keep a personal journal throughout this project which I hope will alert me to any early signs of distress or damage.

2e. Are there any issues arising from the Research Environment, if so how would these be addressed?

I plan to use a semi-structured face to face taped meeting for data collection. It is imperative that the research environment is quiet and private. This will ensure confidentiality, be respectful to the participant individual and facilitate the exploration of the impact of traumatic birth.

My preference will be to use an appropriate room at the university but I am aware the location may be inconvenient for some participants. Dependent on the location of my participants, counselling rooms or meeting rooms maybe available for hire. If it is necessary I will be willing to conduct the interview at the home of participants. I will have to be aware of safety and ensure another person knows where I am; whilst bearing in mind the confidential nature of the visit. Should this need arise I will ensure I discuss this possibility with my research supervisor before any meeting takes place.

Part 3: Sampling & Recruitment

2. How will potential research participants in the study be (i) identified, (ii) recruited to the study? (Include controls if appropriate).

(i) I will advertise for participants on the BACP website and a variety of agencies.

(ii) Interested participants will be sent an information sheet and a pre-interview questionnaire. This will ensure that potential participants meet my selection criteria. It will also ensure that they fully understand the nature of the project and the implications of taking part. If numbers allow, I will recruit on the basis of those offering the most diversity to the sample. For example I would be interested in recruiting mothers whose life had been in danger, as well as those women who felt the birth was traumatic, whilst the medical profession may have viewed it as a normal delivery.

3a. What are the main inclusion criteria for research participants?

My criteria are:

- Women who have experienced a self-defined traumatic birth which resulted in the birth of a robust live child.
- Who are qualified practising counsellors, qualified to a minimum of diploma level.
- Counsellors who have access to supervision to ensure that they have the necessary support.
- Counsellors who have access to personal counselling.
- Who consider themselves to be grounded in their experience and able to discuss the impact without negative repercussions.

It is imperative that I select participants who are robust and grounded in their experience. By choosing qualified practicing counsellors I will be selecting from a group of people who will have undergone extensive personal development and counselling and who understand the importance of continued personal development should issues occur. This grounding will have given them ample opportunity to work through the any issues due to the impact of a traumatic birth. The assumption that counsellors are more likely to have worked through their issues and thus less susceptible to re-traumatization in the re-telling of their experience is supported by Dale (1999)

Practicing Counsellors will also have access to a clinical supervisor and a personal counsellor who can provide continued support should it be required.

3b. What are the main exclusion criteria for research participants?

- Whose traumatic birth experience was less than 5 years ago.
- Who are currently undergoing counselling as a repercussion of the trauma.
- Who are pregnant
- Counsellors who are known to me

My exclusion criteria are based on minimising any risk of re-traumatising the participant.

3c. Sample size.

How many participants will be recruited?	4 - 6

Has the size of the study been informed by a statistical power calculation? Justify your answer.

N/A

3d. Please indicate whether any payment or reimbursement is intended to be made to research participants and, if so the amounts in question. (This should include any reimbursement of expenses).
No payments or reimbursements will be made to the research participants.

3. Please state the relationship, if any, which may/will exist between the researcher(s) and potential participants. (For example, will any of the participants be students, subordinates or colleagues of the investigator, or staff members of the University?)
I do not anticipate that there will be any dual relationships with participants.

4. How will informed consent be obtained from the research participants?	
Consent Form ☒	Other
5. Vulnerable Groups ☐ Applicable ☒ Not Applicable (Move to Q7)	
a. Where a potential participant is under the age of 18 years, what specific measures will be taken to ensure informed consent?	
b. For others who are not in a position to give their own informed consent, how will appropriate consent be sought? (For example, from groups such as people with mental illness or people with learning difficulties). Please specify.	
c. Please state what special or additional arrangements, if any, will be applied, particularly in relation to participant information sheets and gaining informed consent, to safeguard the interests of such participants	
d. Please explain why it is necessary to conduct research involving such participants and whether the required data could be obtained by any other means.	
e. Please state whether, and if so how, participation in the proposed research may/will be of personal benefit to individual participants	

Disclosure statement If you are working with vulnerable adults or children (under the age of 18 years old) please state whether or not you have applied and received a disclosure statement from the Criminal Records Bureau.	
YES ☐	**NO** ☐
If yes then please give the date this was received:	

6.	**What provision will be made for participants for whom English is not their first language?**
	I will only be using people who are fluent in English as the participants are counsellors who are working in the UK and would be expected to be fluent in English.

7.	**Please state what measures will be taken to ensure that participants are able to withdraw from the research at any time without explanation or fear of reprisal should they so wish.**
	Throughout the process I will inform and reassure participants that they can withdraw from research at any time, without reprisal, should they wish to do so. This will be stated in the information sheet given to prospective participants and re-iterated verbally throughout the process.

8.	**Please state what measures will be taken to protect the confidentiality of participants' data. Who will have control and act as custodian of the data generated by the research?** You should consider data in hard copy form, electronic form and audio/audio-visual form. You should explain how you will protect the anonymity of participants during the data collection process, during the analysis and at the end of the research project.
	As the researcher, I will be the custodian of the data. My data will consist of the audio recordings and transcriptions of interviews with my research participants. The interviews will be recorded onto a digital recorder and on my return to my home office will be immediately transferred onto my PC. The original recording will then be deleted from the recorder. A transcription will be made of the recording. All data on my PC is password protected. This is backed up using Dropbox, to which only I have access. To ensure anonymity throughout the process, all participants will be given a pseudonym. Consequently all electronic file names will only include the pseudonym.

Whilst anonymity will be protected in the transcripts and notes, I shall also take the precaution of keeping any hard copies relating to the research participants in a locked desk draw. As I am using Dropbox as a backup, I do not foresee the need to use a pen drive but should I later deem this necessary I will ensure it is pass word protected and stored in a locked desk draw.

Care will be taken to ensure that any parts of the interview which are at risk of allowing the participant to be identified will be “sanitised”. For example the names of hospitals, staff or relatives will be anonymous. This will be done with the participants consent.

If the above is not possible for any reason, and the participant may be identifiable, this part of the interview will not be used in the research. Consent will be sought for the remainder of the interview to be used in the dissertation.

a. Who will have access to the data generated by the study?

I will have access to the data, along with my supervisor and both internal and external examiners.

b. For how long will the data be stored?

All copies of the audio recordings will be destroyed/deleted after the Masters Degree has been awarded. In line with University regulations a hard copy of the data will be kept for 5 years

c. How will data be disposed of?

In line with The University of Chester’s Research Governance and Data Protection Act 1998, all data, whether in an electronic or hard copy format will be deleted in a way which preserves its confidentiality. Computer data will be erased so that it cannot be retrieved. Hard copy data will be disposed of via a professional shredding service with a provision of a Certificate of Destruction, as will any disks and memory sticks.

Part 3: Financial and other arrangements

9. Please state any financial or other interests the Applicant, his/her department/centre, supervisor or employer has in relation to the conduct of this research.

N/A

10. What additional costs will be incurred through the conduct of the research to the University and how are these to be met? Please state whether funding for the research has been secured.

N/A

11. Do you confirm that the necessary arrangements have been, or will be made to comply with the requirements of the UK Data Protection Act 1998 with regard to the computer storage and processing of participants' personal information and generally to ensure confidentiality of such data supplied and generated in the course of the research.	
☒ *provisions have been made under the Data Protection Act*	☐ *provisions will be made under the Data Protection Act*

12. What arrangements are in place for monitoring the conduct of the research? (Please explain below how any complaints or adverse events will be dealt with.
My information sheet which will be sent to prospective participants will contain details of the complaints procedure as laid down in the Research Governance Handbook. I will be attending regular review sessions with my supervisor who will be able to monitor and advise on my research conduct. Should I have any concerns or unease I will raise this immediately with my supervisor. Should I receive any concerns or complaints from my participants, or should any adverse events occur, again I shall seek immediate guidance from my supervisor. My overriding concern is to avoid any harm to my participants. Formal complaints about the research would be addressed to the Dean of the Faculty of Social Sciences, as directed in the Research Governance handbook.

Appendix 16 ``Informed Consent Form 1

M. A. in Clinical Counselling Research
University of Chester

Consent Form: Audio/Digital Recording of Interview

Title of Study: Birth Trauma: An Exploration of Mothers' Experiences of the Impact of a Traumatic Birth.

I …….hereby give consent for the details of a written transcript based on an audio/digital recorded interview with me and Ann Todd to be used in preparation and as part of a research dissertation for the M.A. in Clinical Counselling at the University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the transcript may be seen by Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these individuals are bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy.

I understand that I will have access to the transcribed material and would be able to delete or amend any part of it. I am aware that I can stop the interview at any time or ultimately withdraw the interview, without giving a reason or explanation, at any point before the submission of the dissertation. Upon satisfactory completion of the M.A. in Clinical Counselling the recording will be securely destroyed. The transcripts and related data will be securely stored for a period of five years, by me, the researcher, and then destroyed.

Excerpts from the transcript will be included in the dissertation. A copy of the dissertation will be held in the Department of Social Studies and Counselling and may be made available electronically through Chester Rep, the University's online research repository.

Without my further consent some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Finally I confirm I have read and understood the attached Information Sheet and was given the opportunity for further explanation by the researcher. I believe I have been given sufficient information about the nature of this research, including any possible risks, to give my informed consent to participate.

Signed [Participant]…….

Name- Please Print……

Date ……

Signed
[Researcher] ……
Name –
Please Print……ANN TODD……

Date…….

Appendix 17 ``Informed Consent Form 2

RESEARCH CONSENT FORM

Title of Study:
Birth Trauma: An Exploration of Mothers Experiences of the Impact of a Traumatic Birth.

Name of Researcher: Ann Todd

Name of Participant:……

If you are happy to participate please complete and sign the consent form below.

	Please Initial Box
1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself.	
3. I understand that the interviews will be audio recorded.	
4. I agree to the use of anonymous quotes.	
5. I agree that any data collected may be passed to other researchers.	

I agree to take part in the above project

……	……	……
Name of participant	**Date**	**Signature**

ANN TODD

……	……	……
Name of Person taking Consent	**Date**	**Signature**

……